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NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

NATIONAL HEALTH ACCOUNTS GUIDELINES FOR INDIA

2016

NATIONAL HEALTH ACCOUNTS TECHNICAL SECRETARIAT
National Health Systems Resource Centre
Ministry of Health and Family Welfare
Government of India

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2016

National Health Accounts Technical Secretariat (NHATS)
National Health Systems Resource Centre (NHSRC)
Ministry of Health and Family Welfare (MoHFW)
Government of India

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Secretary

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स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

MESSAGE

For achieving goals of an equitable, efficient and effective healthcare system, the country requires answers to questions such as how much do we spend on health, on what type of services and for whom? Health Accounts is a useful tool in describing a country's health system from an expenditure perspective and to provide answers to these and similar questions. It classifies health expenditures according to consumption, provision and financing which is indispensable for planning allocation of resources to develop strategies that protect people from catastrophic health expenditures and reduce inequities in health. By providing a matrix on the sources and uses of funds for health expenditures and reduce inequities in health. By providing a matrix on the sources and uses of funds for health expenditures, the NHA framework facilitates in tracing how resources are mobilized and managed, who pays and how much is paid for healthcare, who provides goods and services, how resources are distributed across services and beneficiaries etc.

In order to meet the increasing demand for such information by analysts and policy makers on a regular basis and to facilitate systematic measurable description and comparison of financial flows over time, across states, and with different countries these guidelines provide a standard framework for India, comparable to the inter-national framework of System of health accounts 2011. NHA estimates were earlier published for 2001-02 and 2004-05 but they were not accompanied with a guideline for estimation. National Health Accounts Guidelines for India is an important document for the producers of health accounts to understand the framework, know the classifications, methodologies used, sourcing data from various data repositories and finally to produce indicators and results useful for policy making. This guideline will go a long way in institutionalizing National Health Accounts in India.

These guidelines have been developed by the National Health Accounts Technical Secretariat (NHATS) through consultations with senior policy makers and experts from the Union and State Government and institutions working on Health Accounts in India and internationally. It is hoped that these guidelines will be widely used by policy makers, administrators and researchers at the union and state level in arriving at periodic health accounts estimates and analyzing heath expenditures for effective policy making and financing of health programs.

17/5/16

(B.P. Sharma)

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PREFACE

Health expenditure figures for India are regularly quoted in national and international arena and are even a matter of important political discussions in the Parliament. However, no NHA estimates have been published after 2004-05. NHA report 2004-05 only gives a broad methodology for deriving the estimates, without providing a detailed guide to the producers of National Health Accounts on where and how they should collect, classify, and analyse the data from both public and private sources to make it useful for policy making. These 'National Health Accounts Guidelines for India' details the standard methodology to arrive at health expenditure estimates that are comparable with other countries and also across the States within India and also over time. The States should use these guidelines to arrive at state level health estimates so that they take informed financial decisions for better health outcomes.

There is no better time or an opportunity to launch these guidelines as the Government of India looks to provide quality, affordable healthcare services to all its population through integrated multi-sectoral participation. These guidelines will soon be followed by national level estimates on National Health Accounts in India. I hope policy makers and researchers will use these guidelines to generate health accounts at state level that will generate mutually comparable estimates to propel policy making to achieve these goals.

I am grateful to the members of the Steering Committee for providing overall guidance for institutionalization of NHA in India, the members of the Expert Group for providing technical inputs, the team at National Health System Resource Centre led by Dr. Sanjiv Kumar, Executive Director and Dr. Charu C. Garg, Advisor Healthcare Financing for steering the development of these guidelines.

Sheela Prasad
17/5/16

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Acknowledgement

NHA guidelines for India is the outcome of the efforts made by the National Health Accounts Technical Secretariat (NHATS), NHA Cell in the Ministry of Health & Family Welfare in coordination with the Steering Committee on Institutionalisation of NHA in India, the NHA Expert Group (list of members is attached) in consultation with several government Ministries/Departments, organisations and individuals. Our sincere thanks to each and every one for necessary direction, extending continued support and guidance.

My sincere thanks to Dr. Sanjiv Kumar, Executive Director NHSRC for being a pillar of strength. Dr. Sheela Prasad, Economic Advisor MoHFW, Mr. J. Rajesh Director (Planning) MoHFW provided constant encouragement and support in completing these guidelines. These guidelines could not have been completed without persistent hardwork by healthcare financing team at NHSRC comprising Dr. Rahul Reddy, Mr. Tushar Mokashi, Ms. Jyotsna Negi, Mr. Manvirender S. Rawat, and Ms. Maneeta Jain; support by short term/external consultants Dr. Roopali Goyanka, Dr. Pratheeba J, Mr. Vivek Panwar, Ms. Ruchika Sharma and Ms. Dakshu Jindal; and data entry by Mr. Amit Kumar and Ms. Poonam Arya at NHA Cell, MoHFW. I acknowledge the support from Dr. Sakthivel Selvaraj and his team at Public Health Foundation of India specially for their inputs on urban local bodies, enterprises and non-profit institutions and thank their supporters USAID for facilitation. Our sincere thanks to Mr. David Morgan (OECD) and Mr. Chandika Indikadahena (WHO) for technical support. I appreciate the support rendered by all our subgroup members and those that attended several meetings specially Dr. Bandana Sen (NSSO, MOSPI), Ms. Kanchana Ghosh (NAS, MOSPI), Dr. Anup Karan (PHFI), Dr. Indrani Gupta (IEG), Dr. Mita Chowdhury (NIPFP), and Dr. Priyanka Saksena (WHO). Secretarial Assistance by Ms. Neeru Khurana and Ms. Preeti Atwal is gratefully acknowledged.

Dr. Charu C Garg
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List of Abbreviations

ACCORD	Action for Community Organization, Rehabilitation and Development
ACTREC	Advanced Center for Treatment, Research and Education in Cancer
AES	Acute Encephalitis Syndrome
AFMS	Armed Forces Medical Services
ALIMCO	Artificial Limbs Manufacturing Corporation of India
ANC	Ante Natal Care
ANM	Auxiliary Nursing Midwife
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga, Unani, Siddha, and Homeopathy
BCC	Behaviour Change Communication
BE	Budget Estimates
BKKY	Biju Krushak Kalyan Yojana
BPL	Below Poverty Line
CAAA	Controller of Aid Accounts and Audit
CBHI	Community Based Health Insurance
CES	Consumer Expenditure Survey
CGA	Controller General of Accounts
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CHIS	Comprehensive Health Insurance Scheme
CHSS	Contributory Health Service Scheme
CPSU	Central Public Sector Unit
CRS	Creditor Reporting System
CSO-NAD	Central Statistics Office-National Accounts Division
CSS	Centrally Sponsored Schemes
DAC	Development Assistance Committee
DBS	Domestic Budgetary Support
DCI	Dental Council of India
DDG	Detailed Demand for Grants
DGHS	Directorate General of Health Services
DH	District Hospital
DoHFW	Department of Health and Family Welfare

DoSW	Department of ex-Servicemen Welfare
DPE	Department of Public Sector Enterprises
EAC	Externally Aided Component
EAG	Empowered Action Group
ECHS	Ex-serviceman Contributory Health Scheme
EmOC	Emergency Obstetric Care
ESIC	Employee State Insurance Corporation
FCRA	Foreign Contribution Regulation Act
FMG	Financial Management Group
FMR	Financial Monitoring Report
FP	Factors of Provision
FS	Financing Schemes
GFATM	Global Fund to Fight AIDS, Tuberculosis, Malaria
GFR	General Financial Rules
GMP	Good Manufacturing Practices
GoI	Government of India
HAPT	Health Account Production Tool
HBNC	Home Based New-born Care
HC	Healthcare
HCWS	Handloom Weavers' Comprehensive Welfare Scheme
HF	Healthcare Financing
HIS	Health Insurance Scheme
HMS	Hospital Management society
HRG	High Risk Group
HS	National Health and Morbidity survey
HSC	Health Sub Centres
ICHA-HC	Classification of Healthcare Functions
ICHA-HF	Classification of Healthcare Financing Schemes
ICHA-HP	Classification of Healthcare Providers
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education and Communication
IFD	Integrated Finance Division
IIB	Insurance Information Bureau
IMS	Intercontinental Marketing Services
IRDAI	Insurance Regulatory and Development Authority of India
IRMS	Indian Railways Medical Services
ISA	Implementation Support Agency
ISCED	International Standard Classification of Education
ISCO	International Standard Classification of Occupations
JE	Japanese Encephalitis
LTC	Long Term Care
MCI	Medical Council of India
MMU	Mobile Medical Units
MOCA	Ministry of Corporate Affairs

MOHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
MoP	Mode of Provision/Production
MoSPI	Ministry of Statistics and Programme Implementation
MPCE	Monthly Per Capita Consumer Expenditure
MTP	Medical Termination Of Pregnancy
NACP	National Aids Control Program
NE	North East
NEC	Not Elsewhere Classified
NFCDA	National Fund For Control Of Drug Abuse
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHATS	National Health Accounts Technical Secretariat
NHM	National Health Mission
NIDDCP	National Iodine Deficiency Disease Control Programme
NLEP	National Leprosy Eradication Programme
NPCB	National Programme for Control Of Blindness
NPCC	National Program Co-Ordination Committee
NPISH	Non-Profit Institutions Serving Households
NPPA	National Pharmaceutical Pricing Authority
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
NVBDCP	National Vector Borne Disease Control Programme
OCMs	Other Central Ministries
ODA	Official Development Assistance
ODF	Official Development Finance
OECD	Organization for Economic Co-Operation and Development
OOP	Out-Of-Pocket
OOPE	Out Of Pocket Expenditure
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PNC	Post-Natal Care
PNDT	Pre-Natal Diagnostic Techniques
PPP	Public Private Partnership
PST	Primary, Secondary and Tertiary
RCH	Reproductive and Child Health
RE	Revised Estimates
RELHS	Retired Employee Liberalized Health Scheme
RKS	Rogi Kalyan Samiti
RLB	Rural Local Bodies
RNTCP	Revised National Tb Control Programme
ROP	Record Of Proceedings
RRC	Regional Resource Centers

RSBY	Rashtriya Swasthya Bima Yojana
SAST	Suvarna Aarogya Suraksha Trust
SC	Sub-Centre
SDH	Sub-District Hospital
SEWA	Self-Employed Women's Association Of India
SHA	System Of Health Accounts
SHI	Social Health Insurance
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SoE	Statement Of Expenditure
TA	Technical Assistance
TCAM	Traditional, Complementary And Alternative Medicine
THE	Total Health Expenditure
TMC	Tata Memorial Centre
TNMSC	Tamil Nadu Medical Services Corporation
ULB	Urban Local Bodies
UNDP	United Nations Development Programme
USAID	United States Agency For International Development
VAT	Value Added Tax

National Health Accounts Technical Secretariat (NHATS)

Institutionalizing the system of Health Accounts for India was envisaged in National Health Policy, 2002, through establishment of the NHA cell in the Ministry of Health and Family Welfare, Government of India (GoI). The NHA cell was set up and 2 rounds of NHA estimations were conducted. The last NHA estimates for India were for financial year 2004-05 and published in 2009.

Ministry of Health and Family Welfare, Government of India in August 2014 designated National Health Systems Resource Centre (NHSRC) as the National Health Accounts Technical Secretariat (NHATS) with a mandate to institutionalize Health Accounts in India. The NHATS established a roadmap with specific tasks:

1. Establish a Steering Committee (represented by high level Officials of the Central and State Ministries/ Departments related to Health Expenditures) and an Expert Group (Healthcare Financing and NHA experts) to steer the process of institutionalizing NHA and generate periodic reports.
2. Establish a National Health Accounts Framework adapted to the Indian Context mandating a specific classification system for health expenditures in India, comparable to the standardized global NHA framework
3. Establish a country specific technical team that represents all aspects of the health sector to collect data from primary and secondary sources, data validation, analysis, and tabulation using standardized format of NHA tables.
4. Establish processes that track all health sector expenditures at three levels: Revenues for Financing Schemes, Financing Agents, and Providers/Uses – for both public and private sector in India including the external donors and money channelled through non-governmental organizations or philanthropic organizations towards healthcare.
5. Train individuals and institutions in the National Health Accounts Framework and Methodology with an objective to build capacity at the state and central for generating NHA in India and also state level health accounts.
6. Develop a strong network of institutions and organizations at state level; across the country, for periodic conduct of NHA and update health expenditure data at state and national level.
7. Disseminate the Framework for NHA in India, periodic addendums to methodology, reports on healthcare expenditures in India and health financing policy related issues.

Introduction to Guidelines

The Indian health system continues to evolve in response to changing demographics and disease patterns, rapid technological advances, complex financing and delivery mechanisms. To align this rapid change with common health system goals of equity, efficiency and effectiveness of care, information on health system is of prime importance. One of the key questions for policy makers at union and state level is "How much do we spend on health and is it measured in a comparable way across geographies and time" To ensure information related to healthcare expenditure is available to policy makers and analysts it is necessary to bring out periodic health accounts estimates for India. Health accounts estimates are arrived using System of Health Accounts (SHA) 2011 framework, a global standard for systematic description and reporting of financial flows related to healthcare comparable across countries. Developing reliable, timely data that is comparable over time is apriority. This is indispensable for tracking trends in health spending and the factors driving it, which can in turn be used for comparisons across states and countries and predicts growth.

To arrive at national health accounts estimates for India it is required that SHA 2011 is adapted to Indian health system context and a country specific guideline is developed. This guideline is an adaptation of SHA 2011 framework for India and it draws inspiration from the SHA 2011 manual[3] itself and the National Health Accounts for India report 2004-05.[4]

The guideline is presented in various chapters. **Chapter 1** provides the NHA framework for India. **Chapter 2** defines health expenditure boundaries (i.e. which expenditures are considered as healthcare expenditures and which are not). **Chapter 3** describes the SHA 2011 classifications for India**.** Rest of the report is organised around the financing schemes. **In Chapter 4 to Chapter 7,** the methodologies of estimating health expenditures for government, private, health insurance and expenditures by external donors are described. **Chapter 8** is specific to arriving at NHA estimates and key indicators using the health accounts production tool (HAPT)[5]. The HAPT guides health account teams through the entire production process and the health accounts estimation. It serves as a platform to manage complex data sets, reducing issues with missing data and the built-in auditing feature facilitates review and correction of double-counting of expenditures. HAPT's automation of the mapping of data ensures continuity of using same classification and cross walks in the coming years generating comparable trends[6].

3 A System of Health Accounts 2011, OECD, Euro Stat, World Health Organization, OCED Publishing doi:10.1787/9789264116016-en

4 National Health Accounts Cell. 2009. National Health accounts India (2004-05), Ministry of Health and Family Welfare, Government of India, New Delhi.

5 The Health Accounts Production Tool software, publicly released in 2012, was developed by USAIDs Health systems 20/20 project over a two year period with extensive inputs and feedback from Health Accounts country teams and experts as well as the World Health Organization and World Bank

6 WHO website with introduction to NHA and HAPT http://www.who.int/health-accounts/tools/HAPT/en/

CHAPTER 1

NHA Framework

This chapter provides an overview of the purpose of the System of Health Accounts, and the principles from which it has been derived.

1.1 Introduction to System of Health Accounts

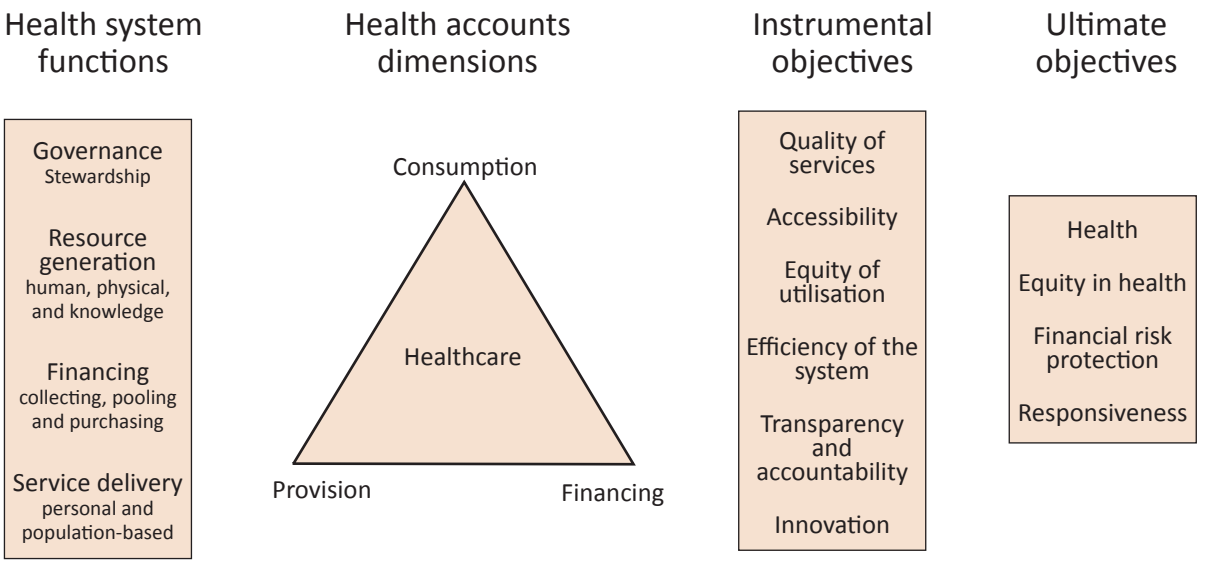
According to System of Health Accounts 2011, health accounts provide a systematic description of the financial flows related to the consumption of healthcare goods and services and a standard for classifying health expenditures according to the three axes of consumption, provision and financing. It provides methodological support in compiling health accounts. All health expenditures are included regardless of how or by whom the service or good is funded or purchased, or how and by whom it has been provided. Due to the multi-factorial nature of health and the multi-sectoral contribution to health status, a health systems framework is much wider, notably with respect to the boundaries of health expenditure. While health systems can vary significantly among countries, SHA aims to enhance comparison of international healthcare expenditure data by delineating the boundary of healthcare according to a functional classification.

The health system framework described by the World Health Organization is defined as consisting of all the organizations, institutions, resources and people whose primary purpose is to improve health (WHO, 2000). Four components or functions (given below) in this framework are essential to reaching the final objectives, which also serve as the standards by which its performance is ultimately measured. Stakeholders performing these functions and the transactions among them vary widely across countries and sometimes even within a country. The national health accounts framework/ guideline for a country is thus developed around this specific health financing context.

- *Governance:* oversight of the system including policy-making and appropriate regulation and monitoring;
- *Resource generation:* investment in personnel, in key medical products and technologies (human, physical and knowledge) and capital goods to produce health workforce; medical goods, pharmaceuticals, knowledge and investment in fixed capital for future use;
- *Financing:* raising revenue for health, pooling resources and purchasing services;
- *Service delivery* (provision): "combination of inputs into a service production process that delivers health interventions to individuals or to the community; aims at producing the best and most effective mix of personal and non-personal services, and making them accessible" (WHO, 2005).

Figure 1 shows how the various dimensions of the SHA sit between the different health system functions and the objectives of the health system framework, reflecting the policy relevance of these dimensions.

Figure 1. Linkage between the frameworks of health systems and health accounts[7]

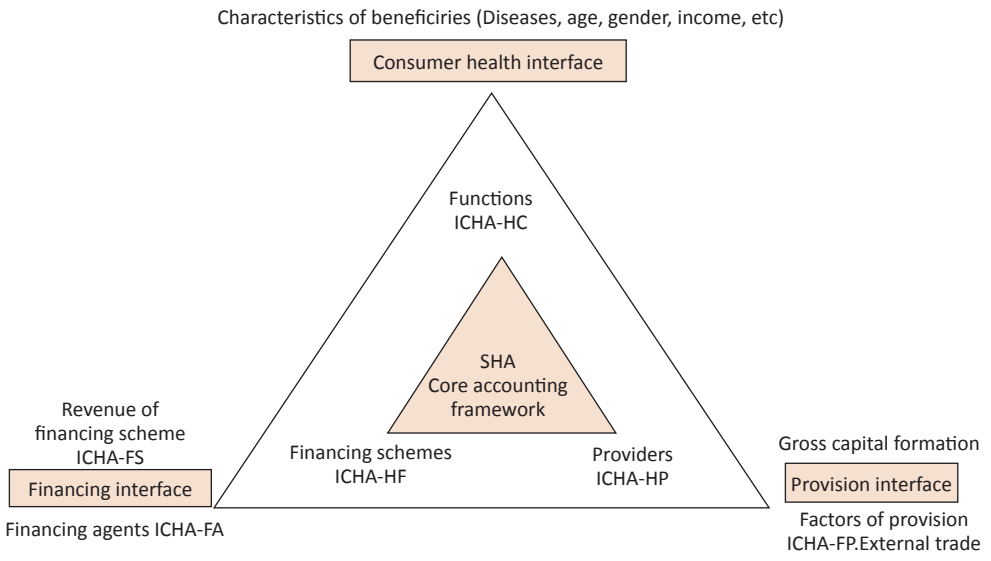


1.2 The Core Accounts Framework of SHA 2011

The core accounting framework is organized around a tri-axial system for the recording of healthcare expenditure, namely classifications of the functions of healthcare (ICHA-HC), healthcare provision (ICHA-HP), and financing schemes (ICHA-HF), as presented in **Figure 2**. These three core classifications address the three basic questions:

- What kinds of healthcare goods and services are consumed?
- Which healthcare providers deliver these goods and services?
- Which financing scheme pays for these goods and services?

Figure 2. The core accounts framework of SHA 2011[8]



7 OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishing Adapted from WHO, 2000

8 OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishingdoi:10.1787/9789264116016-en

Within the health accounting framework, the underlying principle may be formulated as "what is consumed has been provided and financed". There is no one-to-one relationship between healthcare functions and the provision and financing categories. The same type of healthcare goods and services can be consumed from different types of providers and at the same time purchased using various types of financing schemes. But to achieve the tri-axial perspective (consumption-provision-financing), the starting point is to measure consumption. The boundaries of healthcare are set based on this consumption purpose (as described in chapter 2). Around the core accounting framework of the SHA, a number of complementary classifications may be added that are closely linked to one of the three axes.

1.3 Current Expenditure on Health and Gross Capital Formation

Current expenditure on healthcare is defined as final consumption expenditure of resident units on healthcare goods and services. *Gross capital formation* in the healthcare system is measured by the total value of *assets* that providers of health services have *acquired* during the accounting period (less the value of disposals of assets of same type) and that are used repeatedly or for more than one year in the provision of health services. The distinction between current expenditure on healthcare goods and services and capital expenditure in healthcare is important. SHA 2011 framework recommends keeping "current expenditure on health" and "gross capital formation" separate and discourages the use of the aggregate - total health expenditure (THE) at least with respect to how it was used in SHA 1.0.

1.4 Timing of Recording

The timing of recording of final consumption expenditures within SHA 2011 has two elements -

Calendar year versus fiscal year and Accrual versus cash accounting. Fiscal year is the time of recording for India within which the healthcare activities take place i.e. 1st April to March 31st of the next year. The second element is cash accounting that is "actual expenditures'' will be used to arrive at estimates for India.

CHAPTER 2

NHA Boundaries for Healthcare Expenditures in India

To generate health accounts estimates of a country, it becomes necessary to define which 'health- care activities and related expenditures' (both healthcare services and goods) have to be included within this accounting framework. It is necessary to identify and list all these (and also exclude the ones unrelated to healthcare services and goods) in order to collect and analyse the necessary expenditures related to these activities. This chapter presents the information on defining the boundaries for healthcare expenditures for NHA – India.

The SHA 2011 framework states that consumption is the starting point of the concept of health accounts. Thus defining the goods and services consumed for the purpose (functions) of health set the boundary of health accounts. This consumption of goods and services is captured by transactions of valued activities that take place between different actors or organizations. These transactions are recorded in the health accounting framework related to consumption, provision and financing to improve the health status of individuals and of the population as a whole. In health accounts, it is the demand, supply and distribution of health-care goods and services, rather than health *per se,* that define the transactions measured. Consequently, the boundaries are for healthcare, and not of health. Boundary for healthcare is necessary, as common boundaries allow international comparisons for health accounts estimates and it helps in distinguishing core healthcare functions from health related functions.

2.1. Boundaries of Healthcare According to the System of Health Accounts 2011 (SHA 2011)[9]

Boundaries of healthcare according to SHA 2011 are focused on functional classification of healthcare, ICHA-HC that determine if the primary objective of the activity is to improve, maintain or prevent the deterioration of the health status of *individuals*, *groups of the population* or the *population as a whole*, as well as to mitigate the consequences of ill health; including the function of governance and administration of health system and its financing. Qualified medical or healthcare knowledge and skills (according to licensing standards /regulatory specifications of the country) are required to carry out this function, including traditional, complementary and alternative medicine - TCAM - or it can be executed under the supervision of those with such knowledge. The consumption is for the final use of healthcare goods and services of residents. According to this, the framework should include expenditures on the following activity groups:

- Health promotion and prevention
- Diagnosis, treatment, cure and rehabilitation of illness
- Caring for persons affected by chronic illness
- Caring for persons with health-related impairment and disability

9 OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishingdoi:10.1787/9789264116016-en

- Palliative care
- Providing community health programs
- Governance and administration of the health system

Health- related activities that aid but do not belong to healthcare functions e.g. provision of long-term social care, enhancing integration of disabled persons, control of food hygiene, drinking water, environmental protection, and multi-sector promotion of health lifestyles which are not in strict relation to preventive health programs are excluded from the boundary for healthcare expenditures.

There is further demarcation of the activities into two categories.

1. Activities related to current consumption of services to promote, develop and maintain health status.
2. Resource generation like capital formation, medical education and training and research dealing with future healthcare provision, which is mentioned separately, but kept outside the boundary of current healthcare expenditure.

2.2 Boundaries of Healthcare According to SHA 2011: The Borderline Cases

Sometimes, there is no clear line that distinguishes those activities that are "in" the health accounts sphere from those that are "out". This ambiguity goes back to the notion that virtually all activities affect health in some way or another and it is reflected in the unclear border between the health system and the social services, healthcare and medical interventions, etc. Some borderline cases are discussed below.[10]

2.2.1 Borderline between healthcare and other social services[11]

These comprise grey areas when social services involve a significant but not dominant healthcare component in e.g. long-term care for dependent elderly people, home or institutional care such as protective custody in mental health institutions, homes and protected working places for disabled persons and rehabilitation programs for drug addicts. There is significant but not dominant medical component in these services, comprising less than half of the total cost. The estimation of expenditure on healthcare should be done by evaluating their input in the form of labour and /or final use of medical goods.

2.2.2 The borderline between healthcare and other medical interventions[12]

Spa therapy/ Yoga sessions for mainly medical and curative purposes should be distinguished from sessions for recreation or rehabilitation or purpose of general fitness which is outside the boundary. Similarly, cosmetic surgery unrelated to the reconstruction of traumatic damages, *in-vitro* fertilization, etc. falls outside the boundary of healthcare expenditure.

2.2.3 The borderline between healthcare and other government functions

A range of public safety measures (road and vehicle safety, construction and housing standards, veterinarian services and product safety monitoring) even administered by public health authorities, will not be included into the SHA boundaries of healthcare. Installation of drinking water and sanitation system: affects health, but construction of systems with the primary intent to distribute waterfalls outside the health boundary. In contrast, expenditures on water treatment primarily designed to counteract diseases can be considered inside the boundary. Mid-day meal programme/food subsidies/supplementary nutrition programme may not be provided by the Health ministry, but rather by other departments such as social welfare, education and

10 Programs such as Swachh Bharat Abhiyaan, mid-day meal program, other nutrition programs by other Ministries, etc. have policy relevance in Indian context. However, currently, these are all outside the expenditure boundary as per SHA 2011 definitions. They can be considered as health related expenditures or alternatively be mentioned as memorandum items and reported below the line, which still remain outside the boundary of current healthcare expenditures. Totals can just be reported separately for policy consumption, but the items, their definitions and the components of their expenditures that need to be included needs further discussion.

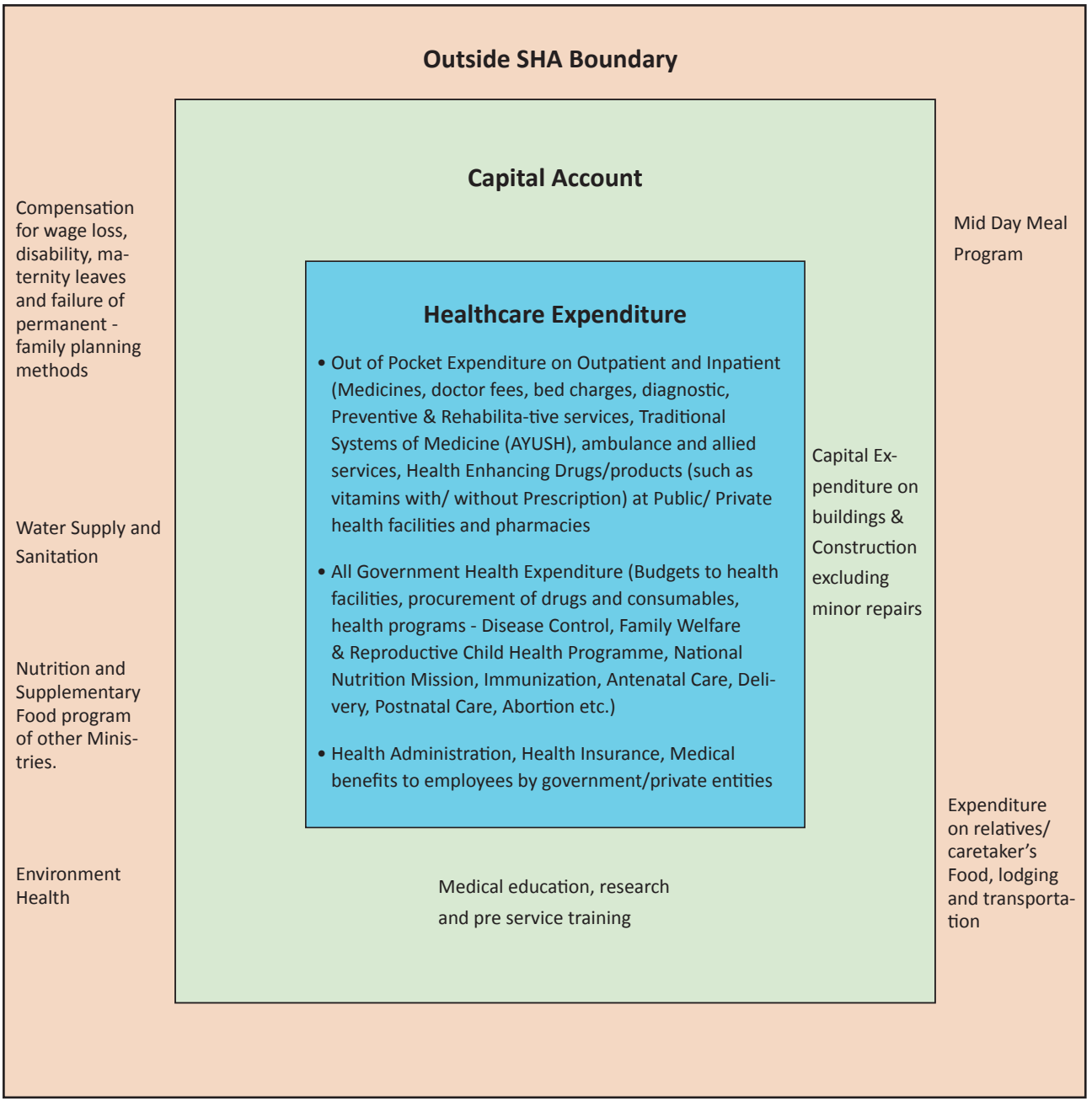
11 A System of Health Accounts, OECD Publishing. OECD, Eurostat, WHO, 2011

12 A System of Health Accounts 2011, OECD, Euro Stat, World Health Organization, OCED Publishing doi:10.1787/9789264116016-en

public distribution system. The primary purpose can help distinguish between those that should be included as health- expenditure and those that should be excluded. If the targeted supplementary feeding programme provides feeding as therapy to assist recovery from acute malnutrition, it should be included. However, a supplementary nutrition programme, by the social welfare department, targeted at children, adolescents, pregnant, and lactating mothers, who are brought to special facilities (*Anganwadi*) for that purpose, nutritional education and counselling to prevent malnutrition, it is outside the ambit of the expenditures boundary of health accounts, as the primary purpose of the program is social services, not healthcare. Similarly, when the primary purpose is to decrease the drop- out rate and increase the enrolment, such as mid-day meal, it should not be included in national health expenditure.

Based on the above description, the health expenditure boundaries for India based on SHA 2011 framework are described in the **Figure 2.1** below. In the respective Chapters 4 to 7 descriptions of boundaries of health expenditures for public, private insurance and external resources are detailed.

Figure 2.1: NHA boundary for India based on SHA 2011



2.3 Major Differences in SHA 2011 and NHA 2004-05 Regarding Boundaries for Health Expenditure

NHA 2004-05 kept, water supply and sanitation, environment health, nutritional and supplementary programs by other Ministries, health enhancing drugs/products (without prescriptions) like *chyavanprash* and vitamins tablets and mid-day meal programme, outside healthcare boundaries. In SHA 2011, Health enhancing drugs which are bought even without prescription, like Vitamin tablets, *chyavanprash*, etc. are now included inside the boundary. Expenditure on 'Traditional' and 'Complementary' medicines was reported below the line (as a memorandum item, and not added in the total health expenditure in SHA.1). NHA 2004-05, however, did include the expenditures on TCAM in health-care boundaries. According to SHA 2011 and for NHA India, expenditures under TCAM are included in the health expenditure boundary and also reported separately.

In Indian context, expenditure incurred on infrastructure was included in total healthcare expenditures in NHA 2004-05. In SHA 2011, there is a separation of current consumption and capital formation. In SHA 2011, expenditure on infrastructure is part of the capital account and is now outside the boundary of current healthcare expenditure. The provision of education and training of health personnel, including the administration, inspection or support of institutions providing education and training of health personnel is also a part of capital account, unless the trainings are on the job trainings, which is included in current health expenditures. Research and development programs directed towards the protection and improvement of human health is also a part of the capital account.

For the NHA 2004-05, only the expenditures under Ministry of Defence, Ministry of Mines, Ministry of Home Affairs, Ministry of Labour and Employment, Ministry of Science and Technology, Department of Communication and Information, Ministry of Posts and Ministry of Railways along with the Ministry of Health and Family Welfare, were included under public expenditure on health. Under the current framework, all ministries and departments under the central and state governments were examined and based on the SHA 2011 criteria, specific line items were identified and described in Chapter 4.

CHAPTER 3

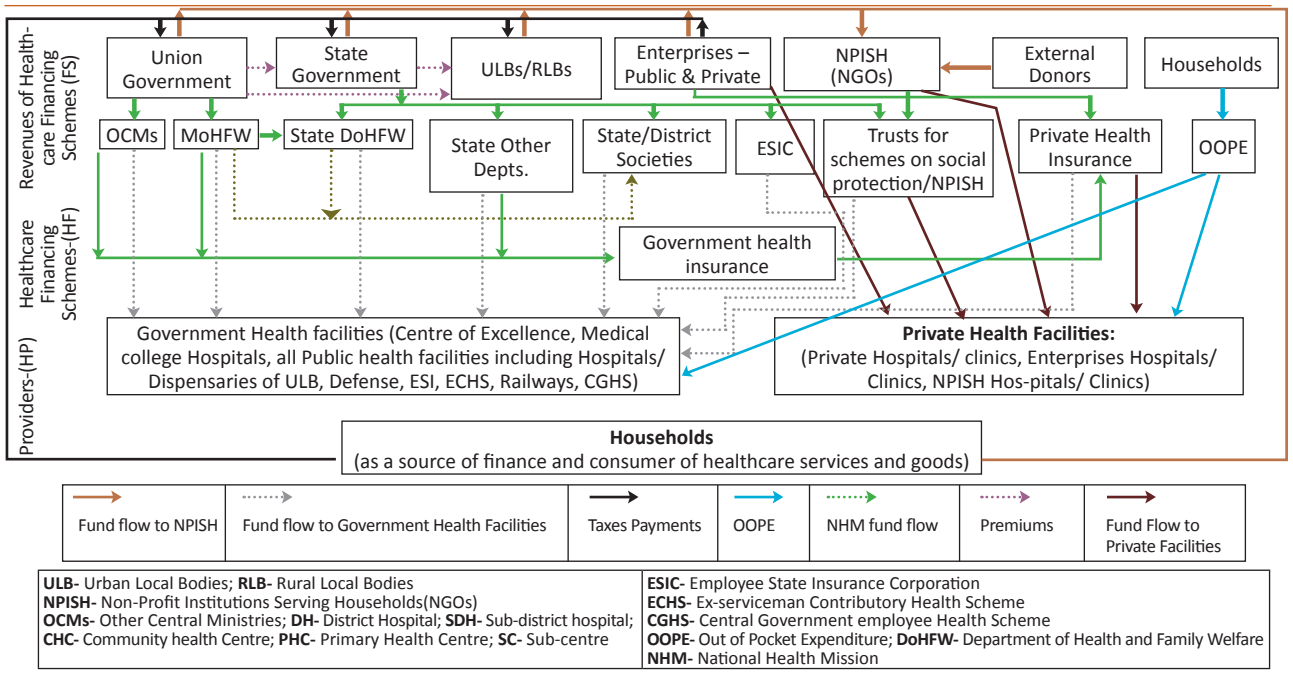
SHA 2011 Classifications for India

SHA 2011 classifications deal in categorizing healthcare expenditures to describe how health is financed in the country, i.e. how financial resources are generated, allocated and used in health systems. Classifications provided by SHA 2011 framework are generic and all the categories given might not be suitable for a country. Country health systems have complex, nationally determined fund flows, providers and healthcare functions that are strongly influenced by culture, politics and economics, with links across economic sectors, public administration and various activities related to social participation.

To achieve the tri-axial perspective (consumption-provision-financing) outlined in section 1.2, the current consumption line item (i.e. expenditure line item/ data) has to be classified based on healthcare functions, providers, healthcare financing schemes, revenue of financing schemes encompassing institutional units of health financing and the related financing agents to account comprehensively for structure of health financing and describe the flow of financial resources in the health system (**Figure 3.1**). In this chapter we present these classifications and their definitions and respective codes as described in the accounting framework for health financing.

It is important to note that these classifications for India are not sacrosanct and might change with the changing healthcare context and fund flows over time; depending on availability of information or data. The NHA team should take this into account and modify the classifications and their codes accordingly.

Figure 3.1: Financial flow of funds in health system



ULB- Urban Local Bodies; **RLB-** Rural Local Bodies
NPISH- Non-Profit Institutions Serving Households(NGOs)
OCMs- Other Central Ministries; **DH-** District Hospital; **SDH-** Sub-district hospital;
CHC- Community health Centre; **PHC-** Primary Health Centre; **SC-** Sub-centre

ESIC- Employee State Insurance Corporation
ECHS- Ex-serviceman Contributory Health Scheme
CGHS- Central Government employee Health Scheme
OOPE- Out of Pocket Expenditure; **DoHFW-** Department of Health and Family Welfare
NHM- National Health Mission

3.1 Classifications for Healthcare Financing Schemes (HF) in India

Healthcare financing schemes are the structural components of the healthcare financing systems. They are the main types of financing arrangements through which the people obtain health services. For example government schemes, social insurance, voluntary insurance and direct out of pocket payments to buy healthcare services. **Table 3.1** presents the classification and respective codes for financing schemes (HF) in India. While we briefly describe each of the schemes below, the relevant details are provided in the respective chapters.

Table 3.1: Classification of financing schemes (HF) for NHA India[13]

Description	SHA Codes
Government schemes and compulsory contributory healthcare financing schemes	HF.1
Government schemes	HF.1.1
Union government schemes	HF.1.1.1
Union government schemes (Non-Employee)	HF.1.1.1.1
Union government schemes (Employee)	HF.1.1.1.2
State/regional/local government schemes	HF.1.1.2
State government schemes	HF.1.1.2.1
State government schemes (Non-Employee)	HF.1.1.2.1.1
State government schemes (Employee)	HF.1.1.2.1.2
Local government schemes	HF.1.1.2.2
Urban Local Bodies schemes	HF.1.1.2.2.1
Rural Local Bodies schemes	HF.1.1.2.2.2
Compulsory contributory health insurance schemes	HF.1.2
Social health insurance schemes	HF.1.2.1
Voluntary healthcare payment schemes	HF.2
Voluntary health insurance schemes	HF.2.1
Primary/substitutory Voluntary health insurance schemes	HF.2.1.1
Employer-based insurance (Other than enterprises schemes)	HF.2.1.1.1
Government-based voluntary insurance	HF.2.1.1.2
Other primary coverage schemes	HF.2.1.1.3
Complementary/supplementary insurance schemes	HF.2.1.2
Community-based insurance	HF.2.1.2.1
NPISH financing schemes	HF.2.2
NPISH financing schemes (excluding HF.2.2.2)	HF.2.2.1
Resident foreign government development agencies schemes	HF.2.2.2
Enterprise financing schemes	HF.2.3
Enterprises (except healthcare providers) financing schemes	HF.2.3.1
Public enterprises (except healthcare providers) financing schemes	HF.2.3.1.1
Private enterprises (except healthcare providers) financing schemes	HF.2.3.1.2
Household out-of-pocket payment	HF.3
All Household out-of-pocket payment	HF.3.3

HF.1 Government schemes and compulsory contributory healthcare financing schemes

Schemes aimed at ensuring access to basic healthcare for the whole society, specific population groups determined and mandated by law or by the government are categorized under this. Schemes included in this category are government schemes, and compulsory contributory social health insurance scheme.

13 Table 3.1 includes all those classification codes for healthcare financing schemes that are relevant in the Indian context. To refer to the entire list of classification codes for healthcare financing schemes kindly refer to page number 165 of SHA 2011 manual.

HF.1.1 Government schemes

Healthcare services provided by the Union[14]; state and local governments (urban and rural local bodies) across the country are categorized as government schemes. According to the Constitution of India, predominant responsibility of providing healthcare services is of the state governments[15]. However all the three levels of government finance and provide healthcare services. Healthcare services are financed through tax and non-tax revenues and a separate budget is determined (at all three levels) for these services. Government schemes are operated primarily by government unit(s) but not necessarily. They can be managed by NPISH or by an enterprise through public private partnerships. For India, these schemes are further classified according to source of financing into union, state and local government schemes; and according to the nature of the beneficiary receiving the healthcare services into government non-employee schemes, government employee schemes.

HF.1.1.1 Union government schemes

These schemes are financed by the union government and classified into non-employee and employee schemes.

HF.1.1.1.1 Union government schemes (Non-Employee)

All schemes that are financed by the union government to provide healthcare goods and services in public and some private health facilities; for national health programs; for interventions for strengthening health systems and related research are included in this category. The entire population of the country has access to these services with no enrolment criteria. Union ministry of health and family welfare is the institution that implements the programs through central institutions/ centres for excellence (hospitals, medical colleges, research institutions etc.), through state government agencies and even through private providers (public private partnerships).

It also implements specific national health programs and disease control programs which operate through health workers and the three-tier public health system across the country. State is the nodal implementation unit and program might differ across states due to their local needs. An important program in recent years that has brought all health programs under a single umbrella is the National Health Mission. The mission focuses on preventive, primary and to an extent secondary care like, reproductive and child health, adolescent health; diseases control programs, health system strengthening, quality assurance and related information, communication and education programs. The entire population is covered under this scheme and they are free of cost at point of service.

Certain union ministries and departments like social justice, minority affairs, labour and employment, atomic energy and others provide health services which are financed through their own respective department budgets and delivered in coordination with their state level counter parts or other national institutions. The service delivery is either through the public health system across states or through department owned centres of excellence, insurance programs for target populations and stand-alone units for occupational health, disabilities and nutrition centres etc.

HF.1.1.1.2 Union government schemes (Employee)

Union government covers medical expenses of its employees, pensioners and their dependents through reimbursement of medical bills or providing care through their own network of health facilities and empanelled public or private providers such as Civil Services Medical Attendance scheme (CSMA), Defence Health Services, Railway Health Services etc.

14 Note: The words “Union Government” and “Central Government” are used interchangeably in this report

15 According to Constitution of India Health is part of the state list.

HF.1.1.2 State/regional/local government schemes

HF.1.1.2.1 State government schemes

Healthcare services financed and provided by the state government are further categorized into non-employee and employee schemes.

HF.1.1.2.1.1 State government schemes (Non-Employee)

The health services financed by the state health department come under this category. The budgetary provision is to provide preventive, promotive and curative health services, through a network of medical institutions such as sub-centres, subsidiary health centres (dispensaries/Clinics etc.), primary health centres, community health centres, Sub-Divisional and District Hospitals, Government medical & dental college hospitals. Several services are also provided under the public private partnership mode, where contractual arrangements of different type are set between the public and private sector including NGOs. State health department also execute functions such as 1. Study the health problems and needs in the state and plan schemes to solve the problems. 2. Provision of curative & preventive services. 3. Provision for control of milk and food sanitation. 4. Prevention of any outbreak of communicable diseases. 5. Promotion of health education. 6. Promotion of health programme such as school health, family planning, Occupational health, etc. 7. Supervision of public health facilities. 8. Establishing training courses for health personnel. 9. Co-ordination of all health services with other state departments such as department of education, etc. 10. Establishment and maintenance of medical institutions with necessary infrastructure.

HF.1.1.2.1.2 State government schemes (Employee)

At State level, all state government employees are reimbursed medical bills by their respective departments. Some states have state government employee schemes through which they provide cashless healthcare services to their beneficiaries and these are managed by the departments on their own or implemented through a separate parastatal agency established for this purpose.

HF.1.1.2.2 Local government schemes

Local governments provide healthcare services financed from their own resources and grants from both union and state governments. When Municipal Corporation/municipality/municipal council provide these services in urban areas these are categorized under HF.1.1.2.2.1 Urban Local Bodies scheme and when provided by Panchayat Raj Institutions in rural areas these are classified under HF.1.1.2.2.2 Rural Local Bodies schemes.

HF.1.2 Compulsory contributory health insurance schemes

Compulsory health insurance involves financing arrangements that ensure access to healthcare for specific population groups through mandatory participation and eligibility based on the payment of health insurance contributions by or on behalf of the individuals concerned.

HF.1.2.1 Social health insurance schemes

Social Health Insurance (SHI) is a financing arrangement that ensures access to healthcare based on a payment of a non-risk-related contribution by or on behalf of the eligible person. The SHI scheme is established by a specific public law, defining, among others, the eligibility, benefit package and rules for the contribution payment. Examples of SHI in India include the Central Government Health Scheme (CGHS) implemented by the Department of Health and Family Welfare (DoHFW) of the Union Government for the benefit of central government employees and pensioners living in 25 cities across India. Employee State Insurance Scheme (ESIS) is compulsory for all employees working in factories registered under the factories act and those earning less than a certain wage (currently Rs. 15000 per month). The employee, employer and the state governments all contribute to it and it is implemented through a parastatal agency called the Employee state insurance corporation (ESIC). Ex-servicemen Contributory Health insurance Scheme (ECHS) covers ex-servicemen and

their dependents. Central Health Services scheme is under the Department of Atomic Energy and Retired Employee Liberalized Health Scheme (RELHS) is under Indian Railway Health Services.

HF.2 Voluntary healthcare payment schemes

Includes all domestic pre-paid healthcare financing schemes under which the access to health services is at the discretion of private actors (though this "discretion" can and often is influenced by government laws and regulations). Included are: voluntary health insurance, NPISH financing schemes, and Enterprise financing schemes.

HF.2.1 Voluntary health insurance schemes

HF2 1.1. Primary/ substitutory voluntary health insurance schemes

This category includes health insurance schemes/policies sold by Indian private and public insurance companies in the market to the population. These voluntary health insurance policies are regulated by the Insurance Regulatory and Development Authority of India. It also includes insurance schemes run by the government for financial protection such as RSBY, Comprehensive health insurance scheme of Tamil Nadu or Aarogyashree etc. Insured can get either cashless treatments or reimbursement of medical bills. Given below are sub-categories.

HF.2.1.1.1 Employer-based insurance (Other than enterprises schemes)

When some large employers provide insurance coverage to employees and their dependents by purchasing a group insurance policy from the private or public insurers available in the market it is categorized as employer based insurance.

HF.2.1.1.2 Government-based voluntary insurance

The union government and the state government implement and finance health insurance schemes to provide cashless medical care to specific population groups for specific diseases (secondary and tertiary care). These schemes are implemented either through department of health or a para-statal agency under it (Trust/Society) or through an insurance company. The government allocates budget for medical reimbursements under these schemes. Coverage for medical benefits is capped at a certain limit (in RSBY it is Rs. 30000 per annum and in Rajiv Gandhi Jeevanadyee of Maharashtra it is Rs.1.5 Lakhs per annum). When implementation is through the insurance company, government contributes annual premium on behalf of the enrolled population. These schemes are not mandated by law and enrolment is voluntary. The household might pay a small contribution in the form of registration fee (Rashtriya Swasthya Bima Yojana) to be enrolled or enrolment is automatic in some schemes like NTR Vaidya Seva or Vajpayee Aarogyashree) depending on certain criteria for coverage (commonly below poverty line households or unorganized work force). Healthcare Services are provided at empanelled public and private health facilities through a cashless system where the hospitals receive reimbursements, avoiding household's payment at point of service.

HF.2.1.1.3 Other primary coverage schemes

Schemes under which individuals or households purchase an insurance policy by paying annual premium for a chosen benefit package and maximum amount of coverage from the private and public insurance companies, are categorised as other primary coverage schemes

HF.2.1.2 Complementary/supplementary insurance schemes

According to SHA 2011, this category includes health insurance schemes that complements or supplements primary insurance[16] Community based health insurance is considered under this category.

16 Insurance can be complementary in two ways: it can cover services excluded from the public system or it can cover cost-sharing obligations (i.e. user charges, co-payments, etc.) required by the compulsory insurance or government health scheme. Supplementary health insurance covers the same services as the compulsory insurance, but ensures faster access and/or enhanced consumer choice of providers (Thomson and Mossialos, 2009).

HF.2.1.2.1 Community-based insurance schemes (including micro health insurance)

Community based health insurance exists in India, most often in rural areas. Members make a small prepayment to the scheme. It is similar to voluntary primary health insurance but organized at the level of the community by the community through a non-governmental organization. Some examples include Self-Employed Women's Association (SEWA), ACCORD/ASHWINI and BAIF etc. Sometimes the community-based insurances use insurance companies for risk pooling and are treated as micro health insurance products by the Insurance Regulatory and Development Authority of India (IRDAI). Thus this category also includes such schemes.

HF.2.2 Not for Profit Institutions Serving Households (NPISH) financing schemes

These are institutions established and operated purely on a philanthropic basis or by the foreign aid received. They may have a network of their own healthcare facilities and /or deliver healthcare services. The households usually do not have to pay to receive any service or sometimes have to pay small user fees to access particular services provided by the NPISH. The revenue is from the donations of general public, aid through government budgets, philanthropist, corporations, foreign aid, user fees etc. This scheme is categorised under:

HF.2.3 Enterprise financing schemes

Large enterprises both in the public and private sector like steel authority of India limited, national thermal power corporation, Tata enterprises, plantations etc., have their own network of health facilities through which they provide healthcare services to the employees and their dependents. These facilities are financed through the enterprises themselves. In case they do not have their own facility, the enterprise may reimburse the medical bills of the employee or pay a lump sum payment for healthcare. These schemes are classified as HF.2.3.1 Enterprise Financing Schemes. Based on ownership, these schemes further classified into HF.2.3.1.1 Public enterprises (except healthcare providers) financing schemes and HF.2.3.1.2 Private Enterprises (except healthcare providers) financing schemes**.**

HF.3 Household out-of-pocket payment

Majority of financing of healthcare in India is through household out of pocket payments. There are three main types. One, where the household makes a payment at point of service at a private or public facility. Two, where the household pays at point of service as part of cost sharing when enrolled in a government scheme (user fees) or compulsory contributory insurance schemes. And the third is through cost sharing (co-payments, deductibles etc.) when enrolled in voluntary insurance scheme. All out of pocket expenditure should be classified as HF.3.3 All Household out-of-pocket payment (which is a new code created to suit the data availability in India)

Institutional units of healthcare financing schemes are those that play the role of providers of revenues for financing schemes (such as Government, households and corporations); and/or the role of financing agents that manage one or more financing schemes. Institutional units and agents can be used interchangeably but to be more specific, financing agents are institutional units that administer health financing schemes in practice: they implement the revenue collection and/or the purchasing of services. Examples include local governments, social insurance agencies, private insurance companies, non-profit organizations and so on. Understanding the total contribution of each institutional sector of the economy is also key information, as this indicates the respective financial burden of each sector.

3.2 Revenues of Financing Schemes (FS) in India

Health accounts provide information both about the contribution mechanisms the particular financing schemes use to raise their revenues, and the institutional units of the economy from which the revenues are directly generated. Revenues of healthcare financing schemes describes this mix of revenue sources for

each financing scheme, for example, government budgets, household's contributions to social security or direct payments for health services are used as source to fund the schemes). For the analysis of revenue-raising, three viewpoints can be taken: where the flows originate; where the flows go; and what is the nature of the flows.

Table 3.2 presents the classification and respective codes for revenues of financing schemes (FS) for India**.** Brief description of each classification is also given.

Table 3.2: Classification of revenues of financing schemes (FS) for NHA India[17]

Description	Code
Transfers from government domestic revenue (allocated to health purposes)	**FS.1**
Internal transfers and grants	FS.1.1
Internal transfers and grants - Union Government	FS.1.1.1
Internal transfers and grants - State Government	FS.1.1.2
Internal transfers and grants - Local government	FS.1.1.3
Urban Local Bodies	FS.1.1.3.1
Rural Local Bodies	FS.1.1.3.2
Transfers distributed by government from foreign origin	**FS.2**
Transfers distributed by Union Government from foreign origin	FS.2.1
Transfers distributed by State Government from foreign origin	FS.2.2
Social insurance contributions	**FS.3**
Social insurance contributions from employees	FS.3.1
Social insurance contributions from employers	FS.3.2
Voluntary prepayment	**FS.5**
Voluntary prepayment from individuals/households	FS.5.1
Voluntary prepayment from employers	FS.5.2
Other domestic revenues nec	**FS.6**
Other revenues from households nec	FS.6.1
Other revenues from corporations nec	FS.6.2
Other revenues from NPISH nec	FS.6.3
Direct foreign transfers	**FS.7**
Direct foreign financial transfers	FS.7.1
All direct foreign financial transfers	FS.7.1.4
Direct foreign aid in kind	FS.7.2
Direct foreign aid in goods	FS.7.2.1
All direct foreign aid in goods*	FS.7.2.1.4
Direct foreign aid in kind: services (including TA1)[18]	FS.7.2.2

FS.1 Transfers from government domestic revenue (allocated to health purposes)

This item refers to the funds allocated from government domestic revenues for health purposes. Fund is allocated through internal transfers and grants.

FS.1.1 Internal transfers and grants

This category refers to transfers within the union government, state and local government towards health purposes. These include revenues from tax and non-tax sources allocated to government schemes - the budget of national health services, government health programmers and also insurance programs implemented by the

17 Table 3.2 includes only those classification codes for sources of healthcare financing schemes that are relevant in the Indian context. To refer to the entire list of classification codes for sources of healthcare financing schemes kindly refer to page number 199 of SHA 2011 manual.

government. This excludes: social insurance contributions paid by government as an employer which is accounted under FS.3. For India with decentralized public administration (and decentralized collection of public revenues), it is necessary to show the role of union, state and local government in providing revenues of health financing schemes. According to the origin of transfers these can be further classified into FS.1.1.1 Internal transfers and grants - Union Government, FS.1.1.2 Internal transfers and grants - State Government and FS.1.1.3 Internal transfers and grants - Local government, FS.1.1.3.1 Urban Local Bodies, FS.1.1.3.2 Rural Local Bodies.

In India, union government finances healthcare services from the union budget. State government finances healthcare from its own budget (tax/nontax revenues and taxes devolved to the states by the union government). In addition to this, it also receives grants from the union government for programs of national public health importance. State department of health is the institutional unit that implements service delivery. Local bodies also collect taxes and allocate budgets for healthcare services from these. Local bodies also receive grants from union and state governments for health.

FS.2 Transfers distributed by government from foreign origin

Transfers originating abroad (bilateral, multilateral or other types of foreign funding) that are distributed through the general government are recorded here. For the financing scheme receiving these funds, the provider of the fund is the government, but the fund itself is from a foreign origin. The origin of the revenue can only be registered at the level of the transaction of the revenue. According to the level of government receiving these, it is categorized into FS.2.1 Transfers distributed by Union Government from foreign origin and FS.2.2 Transfers distributed by State Government from foreign origin.

FS.3 Social insurance contributions

Social health insurance contributions are receipts either from employers on behalf of their employees or from employees, the self-employed or non-employed persons on their own behalf that secure entitlement to social health insurance benefits. Examples are contributions of employees and employers towards ESI and contributions from employees for CGHS. This category excludes insurance contributions paid by the government towards government based voluntary insurance that are already accounted part of FS.1.1. Sub-categories of social insurance contributions are classified as FS.3.1 Social insurance contributions from employees and FS.3.2 Social insurance contributions from employers.

FS.5 Voluntary prepayment

This category refers to voluntary private insurance premiums. Voluntary insurance premiums are payments received from the insured (individual or household) or employer on behalf of the insured that secure entitlement to benefits of the voluntary health insurance schemes. Sub-categories of voluntary prepayment are classified by the type of institutional units paying the revenues as FS.5.1 Voluntary prepayment from individuals/households and FS.5.2 Voluntary prepayment from employers.

FS.6 Other domestic revenues n.e.c

This category includes the sources of households' out of pocket payments, as well as any voluntary transfers from households to health financing schemes, other than those classified under FS.5 and FS.3, Sub Categorized as FS.6.1 Other revenues from households nec, FS.6.2 Other revenues from corporations n.e.c and FS.6.3 Other revenues from NPISH nec

FS.7 Direct foreign transfers

This refers to transfers where revenues from foreign entities directly received by health financing schemes as - Direct foreign financial revenues or goods/services earmarked for health. These revenues are usually grants by international agencies or foreign governments, or voluntary transfers (donations) by foreign NGOs or individuals that contribute directly to the funding of domestic health financing schemes; and Direct foreign aid in kind (healthcare goods and services).

If donations or types of assistance from a foreign source are channelled through government or government agencies, these flows are recorded under FS.2 and not under FS.7. FS.7 is restricted to the direct foreign contributions received by the various schemes. Current transfers for international co-operation in cash or in kind should be distinguished from capital transfers of a similar kind, which would fall under capital formation. Two subcategories of direct foreign revenues are defined - Financial transfers or foreign aid in kind (goods or services); and Bilateral, multilateral or other transfers. The sub-categories of foreign revenues are: FS.7.1 Direct foreign financial transfers and FS.7.2 Direct foreign aid in kind. All the direct financial transfer irrespective of type of donor partner (bilateral or multilateral) are classified as FS.7.1.4 All direct foreign financial transfers and all the direct foreign in-kind transfers are classified as FS.7.2.1.4 All direct foreign aid in goods under FS.7.2.1 Direct foreign aid in goods. While all the expenditure on technical assistance (TA) provided by foreign agencies will be classified under FS.7.2.2 Direct foreign aid in kind: services (including TA).

3.3 Classification for Healthcare Providers (HP) in India

Healthcare providers are the organisations and actors that provide healthcare as their primary activity or one activity among other activities. The main objective of the healthcare provider classification is to capture all the organisations and actors involved in the provision of healthcare goods and services and enabling linkage between healthcare functions (HC) and healthcare financing (HF). The healthcare providers at level one are divided into following 9 categories of providers described below and as given in **Table 3.3**

Table 3.3: Classification for Healthcare provision (HP) in India[18]

Description	Code
Hospitals	**HP.1**
General hospitals	HP.1.1
General hospitals – Government	HP.1.1.1
General hospitals – Private	HP.1.1.2
Mental Health Hospital	HP.1.2
Mental Health hospitals – Government	HP.1.2.1
Mental Health hospitals - Private	HP.1.2.2
Specialised hospitals (Other than mental health hospitals)	HP.1.3
Specialised hospitals (Other than mental health hospitals) Government	HP.1.3.1
Specialised hospitals (Other than mental health hospitals) Private	HP.1.3.2
Providers of ambulatory healthcare	**HP.3**
Medical practices	HP.3.1
Offices of general medical practitioners (Private)	HP.3.1.1
Offices of mental medical specialists (Private)	HP.3.1.2
Offices of medical specialists (Other than mental medical specialists) (Private)	HP.3.1.3
Other healthcare practitioners (Government)	HP.3.3
Ambulatory healthcare centres	HP.3.4
Family planning centres (Government)	HP.3.4.1
Ambulatory mental health and substance abuse centres (Government)	HP.3.4.2
All other ambulatory centres (Government)	HP.3.4.9
Providers of ancillary services	**HP.4**
Providers of patient transportation and emergency rescue	HP.4.1
Medical and diagnostic laboratories	HP.4.2

18 Table 3.3 includes all those classification codes for healthcare providers that are relevant in the Indian con-text. To refer to the entire list of classification codes for healthcare providers kindly refer to page number 130 of SHA 2011 manual.

Description	Code
Other providers of ancillary services	HP.4.9
Retailers and Other providers of medical goods	**HP.5**
Pharmacies	HP.5.1
Retail sellers and Other suppliers of durable medical goods and medical appliances	HP.5.2
All Other miscellaneous sellers and Other suppliers of pharmaceuticals and medical goods	HP.5.9
Providers of preventive care	**HP.6**
Providers of healthcare system administration and financing	**HP.7**
Government health administration agencies	HP.7.1
Social health insurance agencies	HP.7.2
Private health insurance administration agencies	HP.7.3
Other administration agencies	HP.7.9
Other healthcare providers not elsewhere classified (n.e.c)	HP.10.nec

HP.1 Hospitals

Hospitals comprise licensed establishments that are primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing and other health services to inpatients and the specialized accommodation services required by inpatients. Although the principal activity is the provision of inpatient medical care they may also provide day care, outpatient and home healthcare services as secondary activities. Hospitals are further classified into General Hospitals, Mental Health Hospitals and Specialized Hospitals (other than mental hospitals).

HP.1.1 General hospitals

This category encompasses hospitals that are primarily engaged in providing general diagnostic and medical treatment (both surgical and non-surgical) to inpatients with a wide variety of medical conditions that are usually used by inpatients (but also by outpatients). The general hospitals category is further classified into HP.1.1.1 general hospitals government. General Hospital government includes medical college hospitals, district hospitals, sub district hospitals and CHCs. and HP.1.1.2 General hospitals – private nursing home.

HP.1.2 Mental health hospital - government

This category comprises of licensed establishments that are primarily engaged in providing diagnostic and medical treatment and monitoring services to inpatients who suffer from severe mental illness or substance abuse disorders.

HP.1.3 Specialized hospitals

A specialized hospital (as per SHA 2011) is primarily engaged in providing diagnostic and medical treatment as well as monitoring services to inpatients with a specific type of disease or medical condition or for specific group of people. This category is further divided into HP.1.3.1 and HP.1.3.2 public and private specialized hospitals respectively. These include speciality hospitals like cancer, TB and lung diseases, cardiology, neurology etc. Hospitals of AYUSH and exclusively providing maternal and child health are also included.

In addition to this the hospitals providing inpatient curative care through the TCAM are classified as specialized hospitals (other than mental health hospitals) HP.1.3 as per the SHA 2011 manual (pg. no. 133). Therefore, all AYUSH hospitals are classified under HP.1.3.1 Specialized hospitals other than mental hospitals.

HP.3 Providers of ambulatory healthcare

Providers of ambulatory healthcare are establishments that are primarily engaged in providing healthcare services directly to outpatients who do not require inpatient services. Health practitioners in ambulatory

healthcare primarily provide services to patients who visit the health professional's office, or the practitioners visit the patients at home. The providers of ambulatory healthcare are further classified (second level) into medical practices, dental practices, other healthcare practitioners and ambulatory health centres.

HP.3.1 Medical practices

This subcategory comprises both offices of general medical practitioners and offices of medical specialists (other than dental practice) in which medical practitioners holding the degree of a doctor of medicine (Code 2210 ISCO[19]-08, ISCED[20]-97 level 5 and 6) are primarily engaged in the independent practice of general or specialized medicine, including psychiatry, cardiology, osteopathy, homeopathy, surgery and others. These practitioners can operate as individual practitioners or in a group practice in their own or rented offices (*e.g.* centres, clinics) or independently in the facilities of others, such as hospitals or health maintenance organizations (HMO)-type medical centers.

This sub category is further classified into HP.3.1.1 Offices of general medical practitioners (Private), HP.3.1.2 Offices of mental medical specialists and HP.3.1.3 Offices of medical specialists (other than mental medical specialists) (Private).

HP.3.3 Other healthcare practitioners

This subcategory comprises the group of paramedical and other independent health practitioners. (other than medical professions: general or specialist physicians, and dentists), such as chiropractors, optometrists, psychotherapists, physical, occupational, and speech therapists and audiologist establishments who are primarily engaged in providing care to outpatients. In Indian context these also include health sub-centers, Aanganwadi centers, Village health and nutrition sanitation Committees (VHNSC). Some form of legal registration and licensing (implying a minimum of public control over the contents of the care provided) is regarded as a necessary condition in order to be reported as a paramedical practitioner in many countries.

HP.3.4 Ambulatory healthcare centres

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 centers are further classified at the third digit level into Family planning centres (Government) HP.3.4.1, Ambulatory mental health and substance abuse centres (Government) and HP.3.4.2 All Other Ambulatory Centres (Government) HP.3.4.9 Primary Health Centres, Dispensaries, AYUSH Dispensaries.

HP.4 Providers of ancillary services

This category comprises expenditures on establishments that provide specific ancillary type of services directly to outpatients under the supervision of health professionals but excludes expenditures incurred as intermediate outputs to other healthcare providers within an episode of treatment. For inpatient treatment by hospitals, nursing care facilities, ambulatory care providers or other providers, all expenditures that are incurred by households on ancillary services are included here where are not a part of the package of inpatient services. Included are providers of patient transportation and emergency rescue, medical and diagnostic laboratories, dental laboratories and other providers of ancillary services. The providers of ancillary services are further classified into HP.4.1 Providers of patient transportation and emergency rescue, HP.4.2 Medical and diagnostic laboratories and HP.4.9 Other providers of ancillary services.

19 ISCO- International Standard Classification of Occupations

20 ISCED- International Standard Classification of Education

HP.5 Retailers and other providers of medical goods

This item comprises specialised establishments whose primary activity is the retail sale of medical goods to the general public for individual or household consumption or utilisation. Establishments whose primary activity is the manufacture of medical goods, such as making lenses, orthopaedic or prosthetic appliances for direct sale to the general public for individual or household use, are also included, as is fitting and repair done in combination with sale. This category is made up of three subcategories:

HP.5.1 Pharmacies

This subcategory comprises expenditures at the establishments that are primarily engaged in the retail sale of pharmaceuticals (including both manufactured products and those prepared by on-site pharmacists) to the population for prescribed and non-prescribed medicines including vitamins and minerals. Pharmacies operate under strict jurisdiction/licences of national pharmaceutical supervision. Illustrative examples includes dispensing chemists, community pharmacies, independent pharmacies in supermarkets, pharmacies in hospitals that mainly serve outpatients and sometimes also inpatients not getting medicines as part of the package treatment component.

HP.5.2 Retail sellers and other suppliers of durable medical goods and medical appliances

This item comprises establishments that are primarily engaged in the retail sale of durable medical goods and medical appliances such as hearing aids, optical glasses, other vision products and prostheses to the general public for individual or household use. This includes the fitting and repair provided in combination with sales of durable products. Also included are establishments that are primarily engaged in the manufacture of medical appliances as prostheses, where the distribution to the general public, the fitting and the repair is usually done in combination with the manufacture of medical appliances.

HP.5.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods

This subcategory includes all other principal activity retail suppliers of medical goods to the general public for individual or household consumption or utilisation not elsewhere classified.

HP.6 Providers of preventive care

This category comprises organizations that primarily provide collective preventive programs and campaigns/ public health programs for specific groups of individuals or the population-at-large, such as health promotion and protection agencies or public health institutes as well as specialized establishments providing primary preventive care as their principal activity. For India these include ASHA, Multi-Purpose Health worker, community health workers and volunteers under national Public health programs for communicable and non-communicable diseases.

HP.7 Providers of healthcare administration and financing

This item comprises establishments that are primarily engaged in the regulation of the activities of agencies that provide healthcare and in the overall administration of the healthcare sector, including the administration of health financing. While the former relates to the activities of government and its agencies in handling governance and managing the healthcare system as a whole, the latter reflects administration related to fund raising and purchasing healthcare goods and services by both public and private agents.

HP.7.1 Government health administration agencies

This subcategory comprises government administration (excluding social security) that is primarily engaged in the formulation and administration of government health policy, in the administration of

health financing, and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics and so on, including the regulation and licensing of providers of health services. Health departments of regional or municipal governments should be included. This item covers also such establishments as the statistical institutes of a ministry of health (but not institutes administering population-based health registers) and public registers of healthcare providers, as both are part of healthcare system administration.

HP.7.2 Social health insurance agencies

This subcategory comprises the social health insurance agencies (sickness funds) that handle the administration of social health insurance schemes. Sickness funds may also provide the administration of employer's health insurance schemes not offered by the government. Also included is the administration of compulsory social health insurance covering various groups of state employees (army, veterans, railroad and other public transport, police, state officials, etc.). Examples are Directorate of Central Government Health scheme, Employee State Insurance Corporation, etc.

HP.7.3 Private health insurance administration agencies

This subcategory comprises private insurance corporations that may manage more than one type of health insurance scheme at the same time (for example, compulsory private health insurance and voluntary health insurance). This subcategory includes establishments that are primarily engaged in activities consisting of or closely related to the management of insurance (activities of insurance agents, average and loss adjusters, actuaries and salvage administration). It covers the administration of all types of compulsory and voluntary private health insurance.

HP.7.9 Other administration agencies

This subcategory is important for organisations or administrative units that cannot be clearly classified into the above categories, for example, these involved in the generation of financial sources. This category comprises also non-profit institutions serving households (other than social insurance). The health administration of the NPISH has to be covered here only if the administration of health financing or of services is not covered by the other health provider categories. Examples are: NPISH that administer government healthcare financing schemes for special groups of the population, such as students and teachers; community-based voluntary health insurance managed by NPISH.

HP.10.nec Other healthcare providers not elsewhere classified (n.e.c)

All other providers not classified elsewhere will fall under this category. These include health providers within boundaries of autonomous universities, research institutions and international organizations. All expenditures where providers are not specified for out of pocket expenditures and health insurance schemes.

3.4 Classification for Functions of Healthcare (HC) in India

The functional classification in the health accounting framework focuses on the estimation of current spending and involves the contact of the population with the health system for the purpose of satisfying health needs. In an accounting sense, a "function" relates "to the type of need a transaction or group of transactions aims to satisfy or the kind of objective pursued". The classification of functions refers to groups of healthcare goods and services consumed by final users (i.e. households) with a specific health purpose. The functional classification (HC) at the first level is divided into 8 categories and aims to distribute health consumption according to the type of need of the consumer (*e.g.* cure, care, prevention, etc.) as described below and presented in the **Table 3.4.**

Table 3.4: Classification for functions of healthcare (HC) in India[21]

Description	Code
Curative care	**HC.1**
Inpatient curative care	HC.1.1
General inpatient curative care	HC.1.1.1
Specialised inpatient curative care	HC.1.1.2
Outpatient curative care	HC.1.3
General outpatient curative care	HC.1.3.1
Dental outpatient curative care	HC.1.3.2
Specialised outpatient curative care	HC.1.3.3
Unspecified outpatient curative care (nec)	HC.1.3.nec
Home-based curative care	HC.1.4
Rehabilitative care	**HC.2**
All rehabilitative care	HC.2.nec
Long-term care (health)	**HC.3**
All long-term care	HC.3.nec
Ancillary services (non-specified by function)	**HC.4**
Patient transportation	HC.4.3
Laboratory and Imaging services	HC.4.4
Medical goods (non-specified by function)	**HC.5**
Pharmaceuticals and Other medical non-durable goods	HC.5.1
All Pharmaceuticals and Other medical non-durable goods	HC.5.1.4
Therapeutic appliances and Other medical goods	HC.5.2
All Therapeutic appliances and Other medical goods	HC.5.2.4
Preventive care	**HC.6**
Information, education and counselling (IEC) programmes	HC.6.1
Information, education and counselling (IEC) programmes not elsewhere classified (nec)	HC.6.1.nec
Immunisation programmes	HC.6.2
Early disease detection programmes	HC.6.3
Healthy condition monitoring programmes	HC.6.4
Epidemiological surveillance and risk and disease control programmes	HC.6.5
Epidemiological surveillance and risk and disease control programmes not elsewhere classified (nec)	HC.6.5.nec
Preparing for disaster and emergency response programmes	HC.6.6
Governance and health system and financing administration	**HC.7**
Governance and Health system administration	HC.7.1
Governance and Health system administration not elsewhere classified (nec)	HC.7.1.nec
Administration of health financing	HC.7.2
Unspecified governance, and health system and financing administration not elsewhere classified (nec)	HC.7.nec
Other healthcare services not elsewhere classified (nec)	HC.9
Total Pharmaceutical expenditure	HC.RI.1
Traditional complementary and alternative medicine (TCAM)	HC.RI.2

21 Table 3.4 include all those classification codes for healthcare functions that are relevant in the Indian context. To refer to the entire list of classification codes for healthcare functions kindly refer to page number 83 of SHA 2011 manual.

HC.1 Curative Care

Curative care comprises healthcare contacts during which the principal intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury, or to protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function.

In HC.1, the main purpose of curative care remains the same, but the technology and place of provision changes. So, the identified categories are: inpatient, outpatient and home-based care (second level of classification).

The third level of functional classification is based on complexity of care that is being provided. Hence it indicates whether the provided service is general or specialized in nature. The categorization of provided service into general or specialized care is based on the underlying principles:

a. More common healthcare needs can be solved through less complex services (basic or general care) while a narrower set of needs require an increasing level of technological complexity (specialized care);

b. The health system usually operates based on the selectivity of needs, with wider availability of basic or general services, generally at lower cost and with diverse means of use (in dense or scattered population areas). A progressive reduction in service availability is expected for more complex healthcare needs, with treatment requiring higher technology. They are also likely to be of higher cost and often accessed through a referrals system;

c. The disaggregation is relative to the technology and resources available in the whole country. Levels of technology can differ in various countries, but specialized care should always refer to a higher level of complexity than services classified as basic or general.

Thus, the category of curative care has the following functional classification:

- HC.1.1 Inpatient curative care
  a. HC.1.1.1 General inpatient curative care
  b. HC.1.1.2 Specialized inpatient curative care
- HC.1.3 Outpatient curative care
  a. HC.1.3.1 General outpatient curative care
  b. HC.1.3.2 Dental outpatient curative care
  c. HC.1.3.3 Specialized outpatient curative care
- HC.1.3.nec Unspecified outpatient curative care (n.e.c)
- HC.1.4 Home-based curative care

HC.1.2 Day curative care is currently not significant due to non-availability of disaggregated expenditure data. It may be included and classified if such data is available at state level or in the future for India.

HC.2 Rehabilitative care

Rehabilitation services focus on the functioning associated with the health condition. Rehabilitation services stabilize, improve or restore impaired body functions and structures, compensate for the absence or loss of body functions and structures, improve activities and participation, and prevent impairments, medical complications and risks.

Rehabilitation services include consumption of services aimed at reaching, restoring and/or maintaining optimal physical (e.g. complementing body structure through a prosthesis), sensory (e.g. complementing hearing recovery with a prosthesis), intellectual (e.g. recovering memory capability after a stroke), psychological (e.g. reducing depression and stress through supported learning to use a prosthesis) and social functional levels (e.g. by re-establishing control of basic functions such as swallowing and speaking after a stroke), all of which are health consequences of disease, disorders or injury.

It is important to note that all expenditure on rehabilitative care (irrespective of whether rehabilitative care is provided as inpatient, outpatient or day care) should be clubbed together into **HC.2.nec All rehabilitative care.**

HC.3 Long Term care (health)

Long-term care (health) consists of a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency.

From a final use point of view, LTC typically comprises an integrated package of services and assistance to patients with an increased level of dependency (also understood as impairment, activity limitation and/or participation restriction) on a continued or recurrent basis, and over an extended period of time. The greater the dependency level, the more comprehensive the set of services included in the package. A continuum of care can be tracked, from more intensive medical or nursing services, through personal care services, to lower-level social assistance-type services and other social care. This care is aimed at the dependent population with chronic or recurrent psychiatric conditions, such as physically disabled people and mental health and substance abuse patients.

HC.4 Ancillary Services (Non specified by function)

Ancillary services are frequently an integral part of a package of services whose purpose is related to diagnosis and monitoring. Ancillary services do not, therefore, have a purpose in themselves: the purpose is to be cured, to prevent disease, etc. The ancillary service is aggregated within the first-digit purpose class and the second-digit MoP in which it was consumed. For inpatient, day care and hospital outpatient services, they are not usually identified as separate categories. Therefore, only a part of the total consumption of ancillary services is made explicit by reporting the consumption of such services in the "non-specified by function" category, such as when the patient consumes the service directly, in particular during an independent contact with the health system.

This category is further divided into HC.4.3 Patient transport and HC.4.4 Laboratory and imaging services. In case disaggregated expenditure data is available, Laboratory and imaging can be separately classified HC.4.1 and HC.4.2 respectively (as per the SHA 2011 codes).

HC.5 Medical Good (Non specified by function)

Medicines and other medical goods are frequently a component of a package of services with a preventive, curative, rehabilitative or long-term care purpose. In inpatient, outpatient and day care consumption, they are not usually identified separately, except possibly at a more detailed level. Medical goods can also be consumed as a result of being prescribed as part of a healthcare contact or independently in the case of self-prescription. Dispensing may take place within a healthcare establishment, such as a hospital, or by a freestanding retailer of medical goods. However, the diversification of distribution channels has increased the need to recognize the mixed role of independent consumption within the various modes of healthcare provision in many countries. In particular, in many low- and middle-income countries, due to the lack of availability of medicines, both in hospitals and outpatient units, often the relatives or patient need to purchase medicines themselves. This category aims to include all consumption of medical goods where the function and mode of provision is not specified.

HC.5.1 Pharmaceuticals and other non-durable goods

This comprises pharmaceutical products and non-durable medical goods intended for use in the diagnosis, cure, mitigation or treatment of disease. This includes medicinal preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, and oral contraceptives. Fluids required for dialysis, as well as gases used in healthcare, such as oxygen, should also be included when the patient or relatives purchase them directly.

It is important to note that the SHA 2011 classification further classifies HC.5.1 into three subcategories, HC.5.1.1 Prescribed medicines; HC.5.1.2 (Over the counter drugs); HC.5.1.3 Other medical non - durable goods. Due to unavailability of desegregated data in India, a new classification code was created i.e. HC.5.1.4 All pharmaceuticals and other non-durable goods; which includes expenditure on pharmaceuticals and other non-durable goods those not classified under inpatient and ambulatory care.

HC.5.2 Therapeutic appliances and other medical goods

This item comprises a wide range of medical durable goods, such as: Orthotic devices that support or correct deformities and/or abnormalities of the human body, e.g. corrective eye-glasses and contact lenses, hearing aids, orthopaedic appliances such as orthopaedic shoes, orthopaedic braces and supports, surgical belts, trusses and supports; Prostheses or artificial extensions that replace a missing body part, e.g. artificial limbs and other prosthetic devices, including implants: an implant is a medical device made to replace (or supplement) the functionality of a missing biological structure; eg. a variety of medico-technical devices such as powered and unpowered wheelchairs and invalid carriages, electronic and other devices for monitoring blood pressure.

HC.6 Preventive Care

“Preventive services” is defined as having the primary purpose of risk avoidance, of acquiring diseases or suffering injuries, which can frequently involve a direct and active interaction of the consumer with the healthcare system. The second digit preventive care classification in SHA 2011 is based on the type of services and is further divided into the following

- HC.6.1 Information, education and counselling programs
- HC.6.2 Immunization programs
- HC.6.3 Early disease detection programs
- HC.6.4 Healthy condition monitoring programs
- HC.6.5 Epidemiological surveillance and risk and disease control programmes
- HC.6.6 Preparing for disaster and emergency response programmes

In the Indian context all the government funded national health programmes such as National Disease Control Programmes are categorized here. Some of the examples are HC.6.1 Tobacco Free Initiative HC.6.2 Immunization program, HC.6.3 Iodine deficiency Program, HC.6.4 The National program for healthcare of the elderly, HC.6.5 National Disease Control Programmes (communicable and non-communicable) and HC.6.6 Health sector disaster preparedness and management program.

HC.7 Governance and health system and financing administration

These services focus on health system rather than direct healthcare. They are not allocated to the specific individuals, but benefit all health system users; hence they are collective in nature. They direct and support health system functioning. These services are expected to maintain and increase the effectiveness and efficiency of the health system and to enhance its equity. Governments and insurance companies mostly incur these expenditures and are recorded separately.

It excludes the administration and management at the provider’s level like any overhead expenses to be included in the expenditures by service consumed (HC.1- HC.6). For example, if a group of public or private hospitals has a central unit that provides certain common services, such as purchasing, laboratories, ambulances or other facilities, the value of these common services would be taken account as part of the value of those individual services.

The classification for HC.7 is divided at the second level into HC.7.1 Government and health system administration and HC.7.2 Administration of Health Financing.

HC.7.1 Governance and health system administration

The Government and Health System Administration includes careful and responsible management of the wellbeing of the population and comprises of three tasks: providing vision and direction, collecting and using intelligence and exerting influence through regulation and other means. It includes planning, policy formulation and information intelligence for the entire health system. Included activities are as follows:

- Formulation and administration of government policy
- Setting the standards
- Regulation, licensing or supervision of providers/producers
- Management of fund collection
- Administration, monitoring and evaluation of resources

HC.7.2 Administration of health financing

This class involves a subcomponent specific to health financing, regardless of its public and private origin or its public and private provision. It contains the management of the collection of funds and the administration, monitoring and evaluation of such resources. Among the specific services linked to resource mobilization are the identification of members of the schemes; their enrolment; the billing and collection of contributions; and the management of exemptions. Within the pooling function, risk equalization is one important service. As for the purchasing function, the services included are selecting, negotiating, purchasing and contracting with health providers, as well as the claims processing system, which includes gate-keeping, making payments to providers, and patient reimbursement.

HC.RI Reporting items

HC.RI.1 Total Pharmaceutical Expenditure (TPE)

Total measurement of the pharmaceutical consumption is of major relevance in a healthcare functional approach. The total figure for expenditure on pharmaceutical consumption is obtained by adding the explicitly reported part (HC.5.1.1 + HC.5.1.2) and the pharmaceutical component within treatment packages, notably as part of the interaction within the contact for curative care (HC.1), which is expected to be the largest amount, but also part of rehabilitative care (HC.2) and long-term care (HC.3). There may also be amounts incorporated as part of outpatient care from prescribing physicians (part of HC.1.3).

HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

TCAM has been identified as policy relevant in many countries due either to its cultural importance or its high growth rate, both in high- and middle-per capita income countries. Policies related to TCAM are emerging and need to be monitored in India. Mainstreaming of AYUSH has been prominent under government health expenditures and also social health insurance schemes makes it very important in the Indian context more so now by establishment of a separate Union Ministry for AYUSH. Due to the mix of purposes and practices and financing profiles, TCAM systems, therapies and disciplines (including the related medical goods) are a *de facto* sub-class of hospitals, ambulatory care services and retailers and have to be specially extracted and summed up, to be included here as an important policy item.

3.5 Classification by Factors of Provision

Factors of provision are defined in SHA as the valued inputs used in the process of provision of healthcare. Provision involves a mix of factors of production – labour, capital and materials and external services- both health and non-health specific inputs- – to provide healthcare goods and services. To be able to function, providers also have to cover other expenditure on inputs, such as the payment of taxes (*e.g.* VAT). Thus, the factors of healthcare provision account for the total value of the resources, in cash or in kind, used in the provision of healthcare goods and services, and are equal to the amount payable to healthcare providers by

the financing schemes for healthcare goods and services consumed during the accounting period. Spending on factors of provision is related to the current spending for the provision of goods and services.

Table 3.5: Classification of factors of healthcare provision

Description	Code
Compensation of employees	**FP.1**
Wages and Salaries	FP.1.1
Social contribution	FP.1.2
All other costs related to employees	FP.1.3
Self-employed professional remuneration	**FP.2**
Material and supplies	**FP.3**
Healthcare services	FP.3.1
Healthcare goods	FP.3.2
Pharmaceuticals	FP.3.2.1
Other healthcare goods	FP.3.2.2
Non-healthcare services	FP.3.3
Non-healthcare goods	FP.3.4
Consumption of fixed capital	**FP.4**
Other items of spending on inputs	**FP.5**
Taxes	FP.5.1
Other items of spending	FP.5.2

FP.1 Compensation of employees

The compensation of employees refers to the total remuneration, in cash or in kind, paid by an enterprise to an employee in return for work performed by the latter during the accounting period. It measures the remuneration of all persons employed by providers of healthcare in public and private sector, irrespective of whether they are health professionals or not. It includes wages and salaries and all forms of social benefits, payments for overtime or night work, bonuses, allowances, incentives as well as the value of in-kind payments such as the provision of uniforms for medical staff.

If any services are contracted or externally purchased, such as cleaning and restaurant services in hospitals, these are considered as purchases, and the wages and salaries of the staff involved should not be reported under this item.

When shareholders or owners also work for the corporation and receive paid remuneration other than dividends, the shareholders are treated as employees and their remuneration is included under this item.

Students in medical, nursing or other colleges, contributing to the process of production of health services as worker trainees, student nurses and hospital interns, are treated as employees, and any remuneration in cash for the work they do or the training received as in-kind payment is included.

FP.1.1 Wages and salaries of employees

The wages and salaries of employees include remuneration, both in-cash and in-kind, either as regular interval payments or as pay for piecework, overtime, night work, work on weekends or other unsocial hours, allowances for working away from home or in disagreeable or hazardous circumstances, as allowances linked to housing, travel or sickness benefits, ad hoc bonuses, commissions, gratuities, incentives and in-kind provision of goods and services such as meals and drinks, uniforms and transportation required to carry out the work. It excludes social security paid by the employer. Salaries of medical interns, residents or trainee nurses are also included here.

FP.1.2 Social contributions

Social contributions are payments, actual or imputed, to social insurance schemes to obtain entitlement to social benefits for employees, including pensions and other retirement benefits. Included are payments to social security or any form of insurance on behalf of the employees.

FP.1.3 All other costs related to employees

Specific incentives in monetary terms and in kind to ensure service delivery by health personnel under hard conditions; specific geography and disease conditions; and with extreme weather conditions, low salaries, etc. can be recorded here. ASHA incentives for providing outreach services will fall under this category. Expenditure incurred for training of personnel already operational in patient care is included here.

Fringe benefits are also to be recorded here, such as the provision of a car to employees, or the provision of benefits so that the employee obtains a car with a major discount.

FP.2 Self-employed professional remuneration[22]

This class refers to the remuneration of the independent health professional, income of non-salaried self-employed professionals and the complementary or additional income generated through the independent practice of salaried health personnel, which is common in most countries' health systems. Measurement has been approached through surveys and through records from providers.

Self-employed income refers to the final consumption payments made by patients or healthcare beneficiaries typically at practitioner's office and quasi corporations. The income of non-salaried self-employed health professionals is the remuneration for their work and their profits as an owner less the other cost items of their work. These other costs include payments for leasing, interest payments, capital consumption and other inputs used in their practice.

The acquisition of supplies (FP.3) and capital consumption (FP.4) should not be included, neither the cost of capital (FP.5.2 financial and non-financial).

FP.3 Materials and services

This category consists of the total value of goods and services used for the provision of healthcare goods and services (not produced in-house) bought in from other providers and other industries of the economy. All the materials and services are to be fully consumed during the production activity period.

Materials refer to all the healthcare and non-healthcare inputs required for the multiple production activities to be carried out in the health system. They rank from highly specific ones, such as pharmaceuticals and inputs for clinical laboratory examinations, to those with a more universal purpose, such as paper and pens. Materials deteriorated, lost, accidentally damaged or pilfered are included. Materials used over more than one production period are classified as capital (equipment and the like) and are thus excluded from this classification. Usually materials are cheaper than capital goods such as machinery and equipment. From a policy perspective, one of the most important types of materials is pharmaceuticals, for which a subcategory has been specifically created.

FP.3.1 Healthcare services

One reason that healthcare services delivery is so complex is that it may involve a considerable amount of subcontracting of healthcare services, such as diagnosis and monitoring services as imaging and laboratory services, or direct provision of healthcare by specialised personnel, such as rehabilitation, long-term care (health), renal dialysis, some cancer therapy and patient transportation.

This class includes healthcare services purchased by a provider to complement the package of services offered by that health provider that can be offered within the same unit or in a different one. Services used involve the

22 Self-employed professional remuneration is an item that includes more than simply the cost of an independent professional. The separation of the salary part of the self-employed from his profit is very difficult. This profit part is usually included in this "cost" item.

purchase of services produced by another agent. Services consumed usually refer to general services provided by non-health industries, such as security, and payments for the rental of buildings and equipment as well as their maintenance, and cleaning.

FP.3.2 Expenditure on healthcare goods

The pharmaceuticals and medical goods provided to patients are included here. The services supplied to hospital patients using medicaments, prostheses, medical appliances and equipment and other health-related products should also be detailed here.

FP.3.2.1 Pharmaceuticals

All expenditure on drugs and pharmaceutical products such as vaccines and serum should be included here. All goods acquired to increase stocks should not be included, such as medicines to be stored for future use.

FP.3.2.2 Other healthcare goods

Donations of materials and supplies should be treated to reflect purchaser values, so the amounts recorded should be at market prices and net of subsidies minus indirect taxes. When a donation of material or supplies lacks a purchaser price because there is no availability in the local market, the price to be used is the one paid by the entity that has offered the donation.

Includes: Other expenditures on consumable goods, such as cotton, wound dressings and tools used exclusively or mainly at work, for example, clothing or footwear worn exclusively or mainly at work (such as protective clothes and uniforms) are included here. Excluded are also equipment and tools to be repeatedly used, which are part of capital.

FP.3.3 Non-healthcare services

Non-healthcare services such as services for infrastructure (e.g. maintenance of buildings and equipment); any services purchased, such as staff training, operational research, transport, housing, meals and drinks, and payment for the rental of equipment and buildings, are included here. Services used as employees' compensation are excluded. Outsourced ordinary and regular maintenance and repair of fixed assets used in production constitutes cost and is recorded as expenditures here. For in-house regular maintenance, bill for human resources are recorded under FP.1 and any materials used under FP.3.4. Major renovations, reconstructions, or enlargements of fixed assets are to be considered as capital formation and not recorded here.

FP.3.4 Non-healthcare goods

This class involve general goods used for healthcare production, but which are not of a specifically health nature. Examples of non-healthcare goods include office supplies; hospital kitchen supplies (if they are not outsourced services), transport (e.g. fuel and tools to operate vehicles), electricity, water and the like.

FP.4 Consumption of fixed capital

The consumption of fixed capital is a cost of production. It may be defined in general terms as the cost, in the accounting period, of the decline in the current value of the producer's stock of fixed assets as a result of physical deterioration, foreseen obsolescence or normal or accidental damage. It excludes losses associated with damage caused by war or natural disasters. In accounting, the consumption of fixed capital is an economic construct that should be distinguished from depreciation, which is a legal construct. In many cases the two constructs lead to different results. The consumption of fixed capital should reflect underlying capital use as a factor of production at the time the production takes place. Included are estimates on the use of buildings, equipment and other capital goods such as vehicles. Excluded are rentals paid on the use of equipment or buildings, fees, commissions, royalties, etc., payable under licensing arrangements. The latter are included as the purchase of services.

FP.5 Other items of spending on inputs

FP.5.1 Taxes

Taxes are compulsory, unrequited payments, in cash or in kind, made by economic agents to government units. They are described as unrequited because the government provides nothing in return to the economic agent making the payment, although governments may use the funds raised in taxes to provide goods or services to other units, either collectively to the community as a whole or individually. Taxes in the factor cost account comprise taxes on production and taxes on products. These include Value added taxes (VAT) on products, taxes on land or premises occupied, etc.

FP.5.2 Other items of spending

Other spending items include all transactions related to items not elsewhere classified. Transactions recorded here include e.g. property expenses, fines and penalties imposed by government; interest rates and costs for the use of loans; and non-life insurance premiums and claims.

3.6 Classification by Primary, Secondary and Tertiary Care

The 2004-05 NHA report provides information on expenditure by healthcare functions of providing primary, secondary and tertiary care. The definition of these healthcare functions is from the providers' perspective, but it is very difficult and complicated to arrive at a clear undisputed definition of primary, secondary and tertiary care. It is also very important for the policy makers to understand the break-up of healthcare expenditure in terms of primary, secondary and tertiary care (PST). Therefore, owing to the its policy relevance; the complication in defining PST cross classifying providers with functions; and in order to maintain consistency with the 2004-05, same definitions as used in 2004-05 NHA India report can be followed till work on refining the definitions through formation of a Sub-Group under the Expert Group for estimation of National Health Accounts for India is completed.

The definitions used in 2004-05 were as follows:

- **Tertiary Care Services**[23] covers all the medical and teaching hospitals, Regional Post Graduate Centre, PG Institute of Medical Education & Research, reference hospitals, specialty hospitals, leprosy, TB hospitals, Medical colleges, and regional medical colleges.
- **Secondary care** covers district and sub divisional hospitals, ESI hospitals, area hospitals, and community health centres
- **Primary Care** Services includes CGHS Dispensaries/Hospitals in Allopath and Ayurveda, primary health centres, dispensaries, sub centres, homeopath and Ayurveda dispensaries, ESI dispensaries, school health programmes, TB clinics, expenditure on national disease control programmes and family welfare programmes
- **Health Statistics research and evaluation and training** includes National TB Training Institute, Central Leprosy Teaching & Research Institute, National Institute of Communicable disease
- **Medical stores depot and drug manufacture** covers BCG Vaccine Laboratory, Pharmaceutical Laboratory of Indian Medicine and Homeopathy

It is important to note that the PST estimates should be obtained from the cross tabulation of functional classification (HC) and provider classification (HP) and guidelines for these will be provided at a later stage.

3.7 Capital Formation

The investments in healthcare in terms of physical infrastructure, machines and medical equipment, medical education and training, etc. have been separated from the current consumption as per SHA 2011 framework

23 The dividing line between tertiary and secondary care is so thin that it is difficult to classify them in to separate functions in case of MoHFW. Many teaching hospitals provide secondary care functions, which makes it difficult to classify them in to secondary and tertiary. In view of this both have been classified as Tertiary care

from the DDG of the state and Union Governments. Some of the examples of these line items are shown in **Table 3.6**. The classification for capital formation (as per SHA 2011) has not been done for these guidelines and will be added in future. However, the total capital formation should be reported.

It is important to note that NHA 2004-05 provided total expenditure on health as a sum of current consumption expenditure and expenditure on capital formation during the accounting period. However, as suggested in SHA 2011, total current expenditures and capital expenditures would be reported separately.

Table 3.6: Examples of expenditure line items classified under capital formation (HK)

Major Heads	Sub Major Head	Minor Head	Sub Minor Head	Head
2210	1	110	001-33	Urban Health Training Centre, Kota
2210	1	196	001-5	Establishment of District and regional areas
2210	2	101	005-05	Strengthening of Medicine preparation centres (CSS)
2210	2	101	006-01	Grant in aid to Rajasthan Ayurvedic College, Jodhpur
2210	2	789	002-1	Education-help for Rajasthan Ayurveda university
2210	2	789	002-2	Ayurveda university Udaipur
2210	5	105	01-01	Medical University, Jaipur*- Medical Education, Training and Research- Allopathy
2210	6	101	16	Tele medicine planning
2210	6	104	01-01	Establishment regarding control of medicine
2210	6	104	02	Diploma course in pharmacy
2210	6	112	1	Public Health Education
2211		104	01-01	Transport- Capital for maintenance of vehicles and cost of Petrol, Oil and Lubricants (CSS)
4210	1	110	1	Urban Health Services- Hospitals & Dispensaries- Ayurvedic including pharmacy
4210	1	110	2	Modernization, Strengthening and Development of the Department
4210	1	110	3	Works by P.W.D. by Ayurveda Department
4210	1	110	7	Construction of medical and health department
4210	1	110	10-12	Construction of homeopathy hospital and dispensary
4210	1	110	5	Allopathy- Directorate -Medical and Health Services- Major Works
4210	1	789	1	Special Component Plan for SC-Hospitals & Dispensaries
4210	1	796	2	Other Expenditure- Modernization, Strengthening etc of the Department
4210	3	1	1	Direction and administration - medical education building
4210	3	101	1	MERT-Ayurveda-Medical education Building
4210	3	105	1	MERT-Allopathy- Medical College, Jaipur -Major Works
4210	3	105	11	New Medical university

* The name of a Medical college may appear twice in the demand for grant under the sub major head "01-Urban Health Services - Allopathy", which is for the hospital attached to the medical college and is to be treated as current consumption, whereas sub-major head "05"-Medical Education Training and Research" is for education and training and hence treated as capital consumption. Therefore, sub-minor heads with names of medical colleges under "05"should be classified as capital formation or HK, while those under "01"should be classified as current consumption.

CHAPTER 4

Government Health Expenditure

In this chapter, methodology to estimate Government health expenditures for India using The System of Health Accounts 2011 (SHA 2011) is presented. Government health expenditures in India include expenditures on health by Union Government, State Government and Urban and Rural local bodies; which are explained in relevant sections below.

The methodology to estimate Government health expenditures includes (1) identifying government health schemes in the health system; (2) Understanding the expenditure line items in the government budgets; (3) mapping these to the SHA 2011 classifications for health financing scheme (HF), revenues of health financing scheme (FS), healthcare providers (HP) and healthcare functions (HC); (4) development of allocation keys for expenditure line items that have multiple sources of revenue, providers or healthcare functions and require to be split/apportioned; (5) The line items of all the government health schemes are then compiled in a specific excel format, a requirement to use the Health accounts production tool (HAPT).

In this chapter, the specific roles of central government, state governments and local bodies are explained in separate sections (Section 4.1, Section 4.2 & Section 4.3 respectively). The five steps for estimation of health expenditures are presented for each of the above. Each section follows a general pattern - overview, respective schemes on boundaries for healthcare expenditures, data sources, mapping of expenditure line items to SHA 2011 classification and development of allocation keys to split certain expenditure line items.

4.1 Union Government Health Expenditure

Union Government health expenditure includes expenditures by Union Ministry of Health and Family Welfare (MoHFW) and other Union Ministries. Expenditures by the ministries are classified under two prominent schemes - Non-Employee and Employee Schemes. Non-Employee schemes are schemes providing healthcare services for general population through the programs under MoHFW and specific health programs of other Ministries. National Health Mission by MoHFW is a prominent program requiring a special mention under these health programs. In addition to these, several other ministries have their own health programs specific to the needs of their employee or nature of business. Medical reimbursements made to employees and their dependents for medical treatments are common expenditure codes in all ministries and classified under employees programs. Section 4.1.1 describes health expenditures by MoHFW (Non-Employee) for non-employees; Section 4.1.2 describes expenditures on health by other Union Ministries for non-employees. Employees schemes under both are described together in Section 4.1.3.

4.1.1 Health Expenditure by Union Ministry of Health and Family Welfare (Non-Employee)

In this section the health expenditures by MoHFW (non-employee) is described under two specific sub sections, Section 4.1.1.1 describes National Health Mission (NHM) expenditures and Section 4.1.1.2 describes all other expenditures by MoHFW.

The union government expenditures by MoHFW (non- employee) are spread across three main functionaries, The Central Council of Health and Family Welfare[24], Ministry of Health and Family Welfare, and The Directorate General of Health Services. The Union Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of Health & Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. The independent responsibilities of Union Ministry of Health and Family Welfare as per the Constitution of India (as mentioned in the Schedule Seven – Central List/ List I) are as follows:

1. International health relations and administration of port quarantine
2. Administration of Central Institutes such as "All India Institute of Hygiene and Public Health, Kolkata
3. Promotion of research through research centres
4. Regulation and development of medical, pharmaceutical, dental and nursing professions
5. Establishment and maintenance of drug standards
6. Immigration and emigration
7. Regulation of labour in the working of mines and oil fields
8. Coordination with states and with other ministries for promotion of health.

Apart from these, the Ministry also assists States in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance. Moreover, The Union Ministry of Health and Family Welfare has some shared responsibilities with the state government regarding the items having wider ramification at the national level like Family Welfare and Population Control, Medical Education, Prevention of Food Adulteration, Quality Control in manufacture of Drugs etc. These have been laid out in the seventh schedule of the Indian Constitution as joint responsibilities of Union and State Government and are listed in the 'Concurrent List' or 'List III'[25]. The concurrent list includes the following items:

1. Prevention and control of communicable diseases.
2. Prevention of adulteration of foodstufFS.
3. Control of drugs and poisons.
4. Vital statistics.
5. Economic and social planning.
6. Population control and Family Planning
7. Preparation of health education material for creating health awareness through Central Health Education Bureau.
8. Collection, compilation, analysis, evaluation and dissemination of information through the Central Bureau of Health Intelligence
9. National Medical Library
10. Ports other than major and
11. Labour Welfare

Directorate General of Health Services (DGHS) is an attached office of the Department of Health & Family Welfare and has subordinate offices spread all over the country. The DGHS renders technical advice on all

24 The Union Health Minister chairs the **Central Council of Health** and the State Health Ministers are its members. The functions of the council are to consider and recommend broad outlines of policy regard to matters concerning health, like environmental hygiene, nutrition and health education, to make proposals for legislation relating to medical and public health matters and to make recommendations to the Central Government regarding distribution of Grants-in-aid.

25 The Constitution of India provides for a division of powers between the Union (Centre) and states. It divides all the subjects into 3 lists- Union list, state list and Concurrent list. The Concurrent list describes the subjects that are under the joint jurisdiction of the Centre of States

medical and public health matters and is involved in the implementation of various health schemes. Major functions of DGHS are:

1. International health relations and quarantine of all major ports in country and International airport
2. Control of drug standards
3. Maintain medical store depots
4. Administration of post graduate training programmes
5. Administration of certain medical colleges in India
6. Conducting medical research through Indian Council of Medical Research
7. Central Government Health Scheme
8. Implementation of national health programmes
9. Preparation of health education material for creating health awareness through Central Health Education Bureau
10. Collection, compilation, analysis, evaluation and dissemination of information through the Central Bureau of Health intelligence and
11. National Medical Library.

MoHFW plays a pivotal role in the overall public health system of the country and has several responsibilities such as policy making, administration, regulation, implementation, imparting medical education and disaster management to name a few. The ultimate objective is to provide universal access to quality healthcare for people of India.

4.1.1.1 National health mission expenditures

National Health Mission is a central sponsored scheme implemented in all states and union territories, with special focus on EAG and NE states. NHM, previously known as National Rural Health Mission (NRHM), was launched in 2005 with an objective of providing quality healthcare in the remotest rural areas by making it accessible, affordable and accountable. The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resource management, community involvement, decentralization, rigorous monitoring and evaluation against standards, convergence of health and related programmes from village level upwards, innovation and flexible financing and also interventions to improve the health indicators. The major source of funds in NHM is the Grant-in-aid by the central government through MoHFW (75%), with the State contributing 25% of the budget. These central and state shares have changed in 2015-16 to 60: 40. However in North East states, Jammu & Kashmir, Himachal Pradesh and Uttarakhand, state contribution continues to remain at 10%.

Financial Management Group (FMG), MoHFW at the GoI level puts a proposal to the Integrated Finance Division (IFD) for fund release after approval of the state Programme Implementation Plan (PIP) by National Program Co-ordination Committee (NPCC). After the approval, funds are transferred to respective State Health Society. From there, funds are transferred to the District Health Societies (in accordance to the requirements stated in the respective District Health Action Plans (DHAPs)) after taking out funds for state level expenditure. The District Health Society receives funds from SHS through two channels: i) main account for RCH Flexipool, NRHM Additionalities Flexi-pool and Immunization and ii) sub-accounts for National Disease Control Programmes. The District Health Society transfers funds to public health facilities below it. **Figures 4.1 and 4.2** depict the flow of funds under NHM through society route and treasury routes respectively.

Figure 4.1: Fund flow under NHM (Society Route)

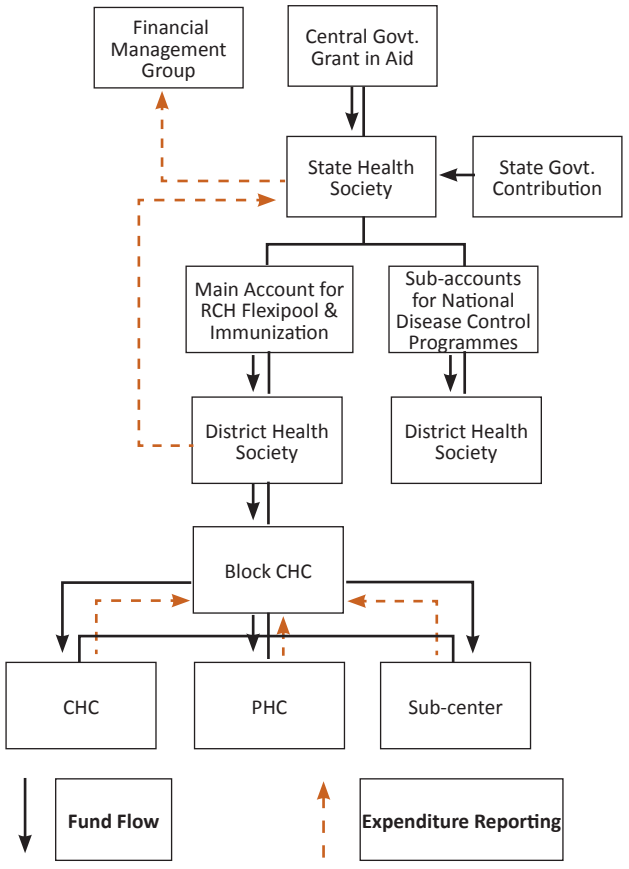
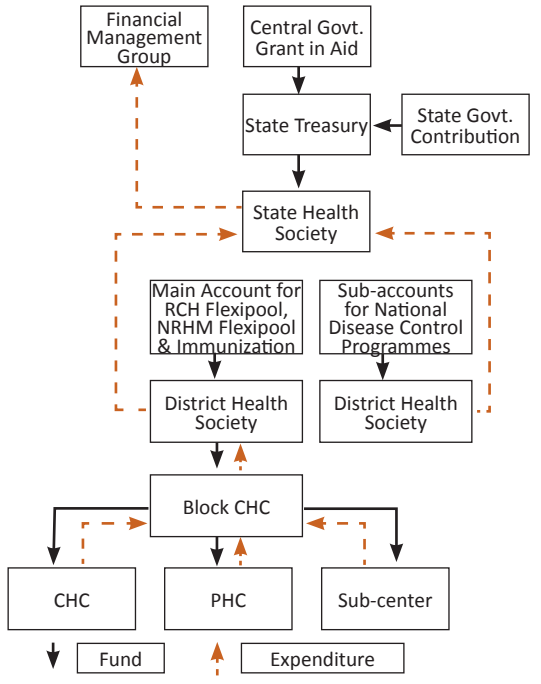


Figure 4.2: Fund flow under NHM (Treasury Route)[26]



4.1.1.1.1. Data Source for NHM

Financial Monitoring Report (FMR) is a financial report that provides component-wise utilization against the budget allocated in the given financial year. Every month, FMRs are prepared at the district level on the basis of Statement of Expenditure (SoE) booked at the block and the facility (CHC/PHC/SC) level. The FMRs are consolidated at the state level and sent quarterly to the Financial Management Group, MoHFW, GoI. The FMRs for the year are obtained from the FMG, MoHFW, GoI. These detailed activity reports help in allocation of the union government health expenditures for NHA purposes. The union government and state governments audited accounts of actual expenditures (shown in demand for grants (DDG)) under NHM are used as a primary data source for expenditures and FMG data along with Record of Proceedings (ROP's) are used for allocating the data according to SHA 2011 categories.

4.1.1.1.2 Boundaries

All line items in FMR are within the healthcare boundary for India.

4.1.1.1.3 Mapping and Classifications

The NHM expenditure line items focus on core goals of the mission that broadly fit the following expenditure categories:

- Reduction in child and maternal mortality

26 From 2014-15 onwards, the funds were transferred to the State Treasury and the State Health Society draws from the Treasury. From thereon, the fund flow is the same as Society Route. This arrangement of fund flow is called the Treasury Route. (Figure 4.2)

- Universal access to public services with emphasis on services addressing women's and children's health and universal immunization.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles

In this section mapping of NHM line items are shown. Usually FMR sheet has 500-600 line items depending on the states.

The classification codes for mapping of expenditure line items requiring special mention are given below.

- ASHAs incentives given for providing Home Based New-born Care (HBNC) and for deliveries are to be classified as HC.1.4 Home based curative care (Pg. 85, SHA 2011) and HP.7 Providers of healthcare system administration and financing for healthcare providers (Pg. 106, SHA 2011)) and FP.1.3 All other costs related to employees.
- All other ASHA incentives are to be classified as HC.6.1 Information, education & counselling programmes for healthcare function (Pg. 103, SHA 2011) and as HP.6 Providers of preventive care for healthcare providers (Pg. 145, SHA 2011) and FP.1.3 All other costs related to employees.
- Trainings are divided into two parts: New trainings i.e. trainings imparting new skills essential for taking up the job and on the job trainings. New trainings are classified as HK (capital formation) e.g. ASHA training whereas on the job trainings are classified as CC (Current Consumption) e.g. EmOC/ MTP training
- All line items reporting expenditure on minor civil works, maintenance and repair are classified as current consumption under the healthcare functions and major additions and new works as capital consumption.
- PPPs, NGOs and Innovations are state specific activities so it is advised to go through each state's NHM budget for expenditure on the activities.
- All national disease control programmes except National Iodine Deficiency Disease Control Programme are to be classified under HC.6.5 Epidemiological surveillance and risk and disease control programmes (Pg. 104, SHA 2011). National Iodine Deficiency Disease Control Programme is to be classified under HC.6.3 Early disease detection programmes (Pg. 103, SHA 2011). Case Management and Procurement of Drugs under HC.1.1.1 and HC.1 and hence, should be classified accordingly.
- Given below are some examples of line items and their classification codes.

Examples of specific items which may be misclassified

Expenditure Head	Classification for Healthcare Functions (HC)	Classification for Healthcare Provision (HP)
Medical Stores Depot/Medicine Store/Rasayan Shalas	HC.1.1.1	HP.1.1.1
Manufacture of Sera and Vaccine	HC.6.2	HP.6
Mental Hospitals/Mental Care Homes	HC.1.1.2	HP.1.2.1
Free transport facility for HIV infected patients (Reimbursement of bus tickets/ Free bus pass)	HC.4.3	HP.4.1
Outsourcing for medical officers, staff, cleaning services, security, diagnostic centres	HC.1.1.1	HP.1.1.1
Strengthening of Medicinal Plant Board and plantation of amla and sahjan	HC.1.1.1	HP.1.3.1
Honorarium to Anganwadi Workers	HC.6.4	HP.3.3
Medical Allowance of Governor, Ex. MLAs, Retired judges, MLAs, other Department personnel	HC.9	HP.10

All possible classification of NHM expenditure line items to SHA codes are shown in **Table 4.1**.

Table 4.1: Identifying NHM expenditure to SHA 2011 framework classifications and codes

	SHA 2011 classification and code
Health financing Scheme (HF)	HF.1.1.1.1 Union government schemes (Non-Employee)
Revenue of the financing scheme (FS)	FS.1.1.1 Internal transfers and grants - Union Government
	FS.1.1.2 Internal transfers and grants - State Government
	FS.2.1 Transfers distributed by Union Government from foreign origin
Healthcare Providers (HP)	HP.1.1.1 General Hospitals -Government
	HP.3.3 Other healthcare practitioners
	HP.3.4.1 Family planning centres
	HP.3.4.9 All other ambulatory centres (Government)
	HP.4.1 Providers of patient transportation and emergency rescue
	HP.6 Providers of preventive services
	HP.7.1 Government health administration agencies
Healthcare Functions (HC)	HC.1.1.1 Inpatient curative care
	HC.1.3.1 Outpatient curative care- General
	HC.1.3.2 Outpatient curative care- Dental
	HC.1.4 Home-based curative care
	HC.4. 3 Patient transportation
	HC.6.1 nec. Information, education and counselling programmes
	HC.6.2 Immunisation programmes
	HC.6.3 Early disease detection programmes
	HC.6.4 Healthy condition monitoring programmes
	HC.6.5 nec. Epidemiological surveillance and risk and disease control programmes
	HC.6.6 Preparing for disaster and emergency response programmes
	HC.7.1 nec. Governance and Health system administration
	HC.RI.1 Inpatient pharmaceutical consumption
	HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

In **Table 4.2** FMR Sheet for NHM data mapped/ cross walked to its respective classification codes. Note that the table provides only a few expenditure line items as an example but broadly covers the most important ones. Table 4.2 is structured with 8 columns describing - Column 1. NHM budget code, Column 2.Description of expenditure line item, Column 3. Expenditure values, Column 4. Current (CC) or Capital (HK) expenditure is indicated, Column 5.Classification of Revenues of Financing Schemes, Column 6.Classification of Financing Scheme, Column 7. Classification of Healthcare Providers, Column 8.Classification of Healthcare Functions. Columns 1-3 are directly obtained from FMG and 4-8 are created for NHA classifications.

Table 4.2: NHM budget classification mapping

S.no. (1)	Description (2)	Expen-diture (3)	Current (CC)/ Capital (HK) (4)	FS (5)	HF (6)	HP (7)	HC (8)
A.1	Maternal Health		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1; HP.4.1; HP.6; HP.7.1	HC.1.1.1; HC.4.3; HC.6.1. nec, HC.6.4; HC.7.1.nec
A.2	Child Health		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1; HP.4.1; HP.6; HP.7.1	HC.1.1.1; HC.4.3; HC.6.1. nec, HC.6.4; HC.7.1.nec
A.3	Family Planning		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1|HP.6; HP.7.1| HP.3.4.1	HC.1.3.1| HC.6.1.nec|HC.7.1.nec

S.no. (1)	Description (2)	Expen-diture (3)	Current (CC)/ Capital (HK) (4)	FS (5)	HF (6)	HP (7)	HC (8)
A.4	Adolescent Reproductive & Sexual Health / School Health		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1| HP.6	HC.1.3.1|HC.6.1.nec |HC.6.3
A.5	Urban RCH		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1|HP.6	HC.1.1.1|HC.1.3.1| HC.6.1.nec|HC.6.4
A.6	Tribal RCH		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1|HP.6	HC.1.1.1|HC.1.3.1| HC.6.1.nec|HC.6.4
A.7	PNDT Activities		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec
A.8	Infrastructure (MINOR CIVIL WORKS) & Human Resources		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1|HP.6; HP.7.1	HC.1.3.1| HC.6.1.nec|HC.7.1.nec
A.9	Training		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1|HP.7.1	HC.1.1.1|HC.1.3.1|HC.6.1 .nec|HC.6.4|HC.7.1.nec
A.10	Programme Management Cost		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec|HC.7.2
A.11.	Vulnerable Groups						
B1	ASHA		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6|HP.7.1	HC.1.4|HC.6.1.nec |HC.6.4|HC.7.1.nec
B2	Untied Funds		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1	HC.1.1.1|HC.1.3.1
B3	Annual Mainte-nance Grants		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1	HC.1.1.1|HC.1.3.1;
B4	Hospital Strengthening		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1	HC.1.1.1|HC.1.3.1;
B5	New Constructions/ Renovation and Setting up		HK	FS.1.1.1|FS.1.1.2			
B6	Corpus Grants to HMS/RKS		HK	FS.1.1.1|FS.1.1.2			
B7	District Action Plans (Including Block, Village)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec
B8	Panchayati Raj Initiative		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec
B9	Mainstreaming of AYUSH		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1		HC.7.1.nec
B10	IEC-BCC NRHM		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.1.nec
B11	Mobile Medical Units		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1		HC.1.3.1
B12	Referral Transport		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.4.1	HC.4.3
B13	PPP/ NGOs		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1	HC.1.1.1|HC.1.3.1
B14	Innovations(if any)			FS.1.1.1|FS.1.1.2	HF.1.1.1.1		

S.no. (1)	Description (2)	Expen-diture (3)	Current (CC)/ Capital (HK) (4)	FS (5)	HF (6)	HP (7)	HC (8)
B15	Planning, Implementation and Monitoring		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec
B16	Procurement		HK				
B17	Regional drugs warehouses		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.1.1.1	HC.1.1.1|HC.1.3.1
B18	New Initiatives/ Strategic Interventions			FS.1.1.1|FS.1.1.2	HF.1.1.1.1		
B19	Health Insurance Scheme		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.2
B20	Research, Studies, Analysis		HK				
B21	State level health resources centre (SHSRC)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec
B22	Support Services		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.1.3.1|HC.6.5
B23	Other Expenditures (Power Backup, Convergence etc)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.7.1	HC.7.1.nec
C	Immunisation		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.1.nec|HC.6.5
D	National Iodine Deficiency Disease Control Programme (NIDDCP)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.5.nec
E	Integrated Disease Surveillance Programme (IDSP)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.5.nec
F	National Vector Borne Disease Control Programme (NVBDCP)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.1.1.1|HC.6.1.nec |HC.6.3|HC.6.5.nec
F.1	DBS (Domestic Budgetary Support)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.5.nec
F.1.2	Dengue & Chikungunya		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.5.nec
F.1.3	Acute Encephalitis Syndrome (AES)/Japanese Encephalitis (JE)		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP6	HC.6.5.nec
F.1.4	Lymphatic Filariasis		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.5.nec
F.1.5	Kala-azar		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.5.nec
F.2	Externally aided component (EAC) - World Bank		CC	FS.2.1	HF.1.1.1.1	HP.6	HC.6.5.nec

S.no. (1)	Description (2)	Expen-diture (3)	Current (CC)/ Capital (HK) (4)	FS (5)	HF (6)	HP (7)	HC (8)
F.3	GFATM Project		CC	FS.2.1	HF.1.1.1.1	HP.6	HC.6.5.nec
G	**National Leprosy Eradication Programme (NLEP)**		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.1.1.1|HC.6.1.nec |HC.6.5.nec
H	**National Programme for Control of Blindness (NPCB)**		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.1.3.1|HC.6.1.nec |HC.6.5.nec
I	**RNTCP (Revised National TB Control Programme)**		CC	FS.1.1.1|FS.1.1.2	HF.1.1.1.1	HP.6	HC.6.1.nec|HC.6.5.nec
J	**Infrastructure Maintenance**		CC	FS.1.1.1	HF.1.1.1.1	HP.3.3, HP.3.4.1|HP.3.4.3|HP.7	HC.1.2.1|HC.6.1.nec |HC.6.2|HC.6.3| HC.6.4| HC.6.5.nec| HC7.1.nec

It is important to note at this point that the classification is always done at the level of activity head and not at the level of above mentioned line items. The FMR sheet has details of several other activities under each of the above mentioned line item and hence should be individually classified. For e.g. the activity head Home based New Born Care (FMR Code A.2.3) falls under code A.2.

4.1.1.2 Other expenditures by MoHFW (Non-employee)

In this section expenditure by MoHFW other than NHM is described. The Ministry of Health & Family Welfare implements various schemes to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. Central assistance is also being provided to strengthen the medical, disaster management, redevelopment of hospitals and dispensaries etc. In addition to this the MoHFW also has several other programs pertaining to the family planning and population control, Information Education and Communication (IEC), Medical Education and Research, quality control of food and drugs, numerous training programs, AIDS control program, mainstreaming of Ayurveda, Yoga, Unani, Siddha, and Homeopathy (AYUSH) and provision of healthcare through alternative or other systems of medicine. Since November 2014, AYUSH is a separate ministry and their expenditures will be detailed as part of other ministries.

National Family Welfare Program

The National Family Welfare Program initiated in the year 1952 is one of the oldest programs of MoHFW. The major activities undertaken in this program are promoting family planning methods like spacing, oral contraception, condoms, IUD insertions and permanent sterilization methods for both males and females, distribution of condoms, incentivizing and providing family planning operations through rural and urban family planning centres and other public health facilities. 'National Family Planning Indemnity Scheme' under which clients are indemnified in the eventualities of deaths, complications and failures following sterilization is an integral part of the National Family Welfare Program. The program is completely funded by the Union Government, implemented at the state level and the expenditure is reflected under the major head 2211 in the Union and State health departments DDGs.

Information, Education and Communication

The Information, Education & Communication (IEC) strategy aims to create awareness and disseminate information regarding the benefits available under various schemes/programmes of the Ministry and to

guide the citizens on how to access them. The objective is also to encourage build-up of health seeking behaviour among the masses in keeping with the focus on promotive and preventive health. The IEC strategy has catered to the different needs of the rural and urban population through the various tools such as print media, television, radio, social media and special camps, used for communication. The program is completely funded by the Union Government and expenditures are noted under 2210 and considered current consumption.

Partnership with NGOs

The NGO Division in this Ministry releases grants-in-aid to Regional Resource Centers (RRCs) such as VHAA, Assam; HLFPPT, Andhra Pradesh; CHETNA, Gujarat; CINI, Kolkata; PFI, MAMATA and VHAI in New Delhi; FPAI, Mumbai, Swasthya Shikshya, Odisha and The Gandhigram Institute of Rural Health & Family Welfare Trust, Tamil Nadu, for providing technical support to Mother NGO/Field NGO to conduct capacity building programmes for implementation of the Reproductive and Child Health program. Hence, MOHFW expenditures are recorded as the source and the NGOs manage these schemes.

Training Programs

The Basic Training of ANM, LHV, MPW (M), RCH training, Adolescent health, etc. is provided through these training programs which are centrally sponsored and reflects under the major head 2211 in the state and union ministry DDGs. These should be classified as capital expenditure as per SHA 2011.

Medical Education and Research

The Union Government has set up regulatory bodies such as Medical Council of India (MCI) and Dental Council of India (DCI) for monitoring the standard of medical education, promoting training the research activities. This is being done with a view to sustain the production of medical and para-medical manpower to meet the requirements of healthcare delivery system at the Primary, Secondary and Tertiary levels in the country. Upgrade and further strengthen medical education institutions in the country through schemes for strengthening and upgrading existing medical colleges in states to increase Post graduate seats and build new medical colleges attached with existing district hospitals in the country and conducting pre-medical test for admissions to medical colleges across the country. All these are considered as part of Capital Formation in the system of Health Accounts.

National AIDS Control Program (NACP)

The NACP phase IV, another centrally sponsored scheme, was introduced for intensifying and consolidating prevention services with a focus on High Risk Group (HRG) and vulnerable population, increasing access and promoting comprehensive care, support and treatment, expanding IEC services for general population and high risk groups with a focus on behaviour change and demand generation, building capacities at national, state and district levels and strengthening the Strategic Information Management System.

These programs/ schemes are described under the budget head 2210 and 2211 of DDG of MoHFW. The SHA classification and their relevant codes are given in **Table 4.3.** A list of all the major heads from Union and State Governments' DDG under which health expenditures were booked in the FY 2013-14 is provided for reference.

Table 4.3: Identifying MoHFW expenditure to SHA 2011 framework classifications and codes

	SHA 2011 classification and code
Health financing Scheme (HF)	HF.1.1.1.1 Union government schemes (Non-Employee)
Revenue of the financing scheme (FS)	FS.1.1.1 Internal transfers and grants - Union Government
	FS.2.1 Transfers distributed by Union Government from foreign origin

	SHA 2011 classification and code
Healthcare Providers (HP)	HP.1.1.1 General Hospitals - Government HP.1.2 Mental health hospitals - Government HP.1.3.1 Specialised hospitals - Government HP.3.3 Other healthcare practitioners HP.3.4.1 Family planning centres HP.3.4.9 All other ambulatory centres (Government) HP.4.1 Providers of patient transportation and emergency rescue HP.6 Providers of preventive services HP.7.1 Government health administration agencies
Healthcare Functions (HC)	HC.1.1.1 General Inpatient curative care HC.1.1.2 Specialised inpatient curative care HC.1.3.1 Outpatient curative care - General HC.1.3.2 Outpatient curative care - Dental HC.1.3.3 Outpatient curative care - Specialised HC.2.nec Rehabilitative care HC.4. 3 Patient transportation HC.6.1.nec Information, education and counselling programmes HC.6.2 Immunisation programmes HC.6.3 Early disease detection programmes HC.6.4 Healthy condition monitoring programmes HC.6.5.nec Epidemiological surveillance and risk and disease control programmes HC.6.6 Preparing for disaster and emergency response programmes HC.7.1.nec Governance and Health system administration HC.9 Other healthcare services not elsewhere classified (nec) HC.RI.1 Inpatient pharmaceutical consumption HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

4.1.1.2.1 Data Sources

The Union Government health expenditure data has been sourced from the DDG of Ministry of Health and Family Welfare. The data is presented in the Demand No. 47 – Department of Health and Family Welfare, Demand No. 48 – Department of AYUSH[27], Demand No. 49 – Department of Health Research and Demand No. 50 – Department of AIDS control. The DDG of MoHFW was procured from the Economic Advisors Office, MoHFW, GOI.

The Detail Demand for Grants (DDG) of a department of any Central Ministry is the document that provides estimates of expenditure from the Consolidated Fund, included in the annual financial statement. The DDGs includes provisions with respect to revenue expenditure and capital expenditure, together with loans and advances. Generally, one demand for grant is presented in respect of each ministry or department. However, for large ministries and departments, more than one demand is presented.

A DDG for a given financial year includes the total provisions required for a service, i.e. provisions on account of revenue expenditure, capital expenditure, grants and also loans and advances relating to that service. It gives item wise details of government receipts and expenditure for three consecutive years, i.e., Actual expenditures/Accounts for the year t-2, Revised estimates (RE) for the year t-1 and Budget estimates (BE) for the given year. A DDG for financial year 2015-16 contains the details of government receipts and expenditures under the following three heads

1. Actual for the year 2014-15

27 As Department of AYUSH has become independent ministry the DDG may change.

2. Revised estimates for the year 2014-15
3. Budget estimates for the year 2015-16

Hence, for NHA estimates for year 2013-14, budget book for 2015-16 will be used.

The Detailed Demands show break-up of estimates by objects of expenditure, provisions of programmes/ organizations individually. The Detailed Demands for Grants show the further break-up by reflecting the 'Object' wise expenditure. Plan and Non Plan provisions are also shown distinctly. Each DDG is divided into sectors (e.g. Social Services, Economic Services, etc.), which may in some cases be further divided into sub- sectors (e.g. Health and Family Welfare, Agriculture and allied services, etc.) and then into the six tiers of accounting classification[28]. The numbers of classification in the Detailed Demands for Grants are not allowed to go beyond the standard six tiers given below:

1.	Major Head	4 digits (Function)
2.	Sub-Major Head	2 digits (Sub-Function)
3.	Minor Head	3 digits (Programme)
4.	Sub-Head (Sub-Minor Head)	2 digits (Scheme)
5.	Detailed Head	2 digits (Sub-Scheme)
6.	Object Head	2 digits (Object Head or Primary Units of Appropriation)

The main unit of classification in accounts is the major head, which is further divided into sub-major head, each of which is then divided into minor heads, each of which has a number of sub-ordinate heads, generally known as sub-heads. The sub-heads are further divided into detailed heads and object heads. Major Heads generally correspond to 'Functions' of Government (e.g. Medical and Public Health – 2210 and Family Welfare – 2211) provided by Government, while minor heads subordinate to them identify the Programme undertaken to achieve the objectives of the function represented by the major head.

A 'detailed head' indicates the object or nature of expenditure on a scheme or activity or organization in terms of inputs such as 'Salaries', 'Office Expenses', 'Grants-in-Aid', 'Loans', 'Investments' etc. For example: Salary of Rs. 55000 drawn for an allopathic doctor employed in an urban dispensary will be classified as under:

Major Head	2210 Medical and Public Health
Sub-Major Head	01 Urban Health Services – Allopathy
Minor Head	110 Hospitals and Dispensaries
Sub-Minor Head	XX Dispensaries
Object Head	01 Salary

As per the provision of Constitution of India, it is mandatory to have uniformity in the structure of the accounts of Government of India and the State Governments up to the first three tiers of classification i.e. the Major Heads, Sub-Major Heads and the Minor Heads. The bottom three tiers viz. the Sub-Head, Detailed Head and the Object Head have been delegated to the State Governments and Ministries/Departments and can be opened up to suit their requirements.[29]

4.1.1.2.2 Boundaries for Union Government health expenditure (MoHFW)

All expenditure recorded in the Detailed Demand for Grants of MoHFW fulfils the criteria for being included in the boundary of healthcare expenditure.

28 Under Article 150 of the Constitution, the accounts of the Union and States shall be kept in such form as the President may on the advice of the Comptroller and Auditor General, prescribe.

29 **Note:** It is important to note at this point that the actual classification of healthcare expenditures in to functional (HC), provider (HP), healthcare financing schemes (HF) and revenues of healthcare financing schemes (FS), etc. as per the SHA 2011 framework, is done at the level of Sub-head/ Sub-Minor head.

4.1.1.2.3 Mapping and Classifications

Expenditure line items for each Union Government (MoHFW) health scheme are sourced from the data sources mentioned in the scheme description. The SHA 2011 framework requires capital expenditure to be separated from the current expenditure as all investments in the health sector (for e.g. Construction of buildings, medical education, research etc.) that will be consumed for a longer duration are treated separately. Thus, to begin with, the healthcare consumption expenditure has to be first divided into current and capital expenditure. This can be done at two levels for the government health expenditures. Firstly at the level of major heads where the major heads like 4210 and 4211 can be directly considered as "capital" expenditure.[30] Secondly, within the major heads 2210 and 2211, at the level of sub minor head (the heads/ line items used for classification) all line items reporting capital expenditure should identified and separated from current consumption expenditure. For e.g. the line items pertaining to medical education, training and research components that appear under the major head 2210 are separated from current consumption since expenditure on medical education, training and research (as per the SHA 2011 manual) should be treated as "capital" expenditure. It is important to be noted that the actual classification of current expenditure should be done at the level of sub-minor head of budgetary coding, as the scheme description at this level is the most appropriate for SHA 2011 classification. At any point where information is not sufficient or there is any difficulty in decision-making, it is recommended to refer to the previous or later budgetary codes.

The DDGs Sheet for other union government expenditure line items and mapping to SHA 2011 codes is shown in **Table 4.4**. Column 1. Major Head, Column 2. Sub Major Head, Column 3. Minor Head, Column 4. Sub Minor Head, Column 5. Description of Sub Minor Head (expenditure line item), Column 6. Expenditure, Column 7. Current (CC) or Capital (HK) expenditure is indicated, Column 8. Classification of Revenues of Financing Schemes (FS), Column 9. Classification of Financing Scheme (HF), Column 10. Classification of Healthcare Providers (HP), Column 11. Classification of Healthcare Functions (HC). Columns 1-6 are as provided in the DDG document. Columns 7-10 need to be reviewed every year to revise any changes required in the coding of the line items.

Table 4.4: Union MoHFW budget Classification and mapping to the SHA 2011 codes

Major Head (Code) (1)	Sub Major Head (Code) (2)	Minor Head (Code) (3)	Sub Minor Head (Code) (4)	Description Sub Minor Head (5)	Expendi-ture (6)	CC/ HK (7)	FS (8)	HF (9)	HP (10)	HC (11)
2210	1	1	3	Direction & Administration-Directorate General of Health Services		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	1	1	4	National Medical Library		HK				
2210	1	110	19	Safdarjang Hospital		CC	FS.1.1.1	HF.1.1.1.1	HP.1.1.1	HC.1.1.2
2210	1	110	21	Central Institute of Psychiatry, Ranchi		CC	FS.1.1.1	HF.1.1.1.1	HP.1.2.1	HC.1.1.2
2210	1	110	22	All India Institute of Physical Medicine & Rehabilitation, Mumbai		CC	FS.1.1.1	HF.1.1.1.1	HP.1.3.1	HC.2.nec

30 Controller General of Accounts (CGA) defines the Major, Minor and Sub-Heads with respective codes and the same are followed by the Union and State Government in the budget books.

Major Head (Code) (1)	Sub Major Head (Code) (2)	Minor Head (Code) (3)	Sub Minor Head (Code) (4)	Description Sub Minor Head (5)	Expendi-ture (6)	CC/ HK (7)	FS (8)	HF (9)	HP (10)	HC (11)
2210	1	110	23	Kalawati Saran Childrens' Hospital, New Delhi		CC	FS.1.1.1	HF.1.1.1.1	HP.1.3.1	HC.1.1.2
2210	1	800	14	Dept. of Canteen (Safdarjang Hospital)		CC	FS.1.1.1	HF.1.1.1.1	HP.1.1.1	HC.1.1.2
2210	1	800	19	GIA to Hospital Waste Management		CC	FS.1.1.1	HF.1.1.1.1	HP.1.1.1	HC.1.1.2
2210	1	800	21	St. John Ambulance-Grants-in-aid		CC	FS.1.1.1	HF.1.1.1.1	HP.4.1	HC.4.3
2210	1	800	29	Purchase of Materials in India & Abroad		CC	FS.1.1.1	HF.1.1.1.1	HP.1.1.1	HC.1.nec
2210	1	800	25	Clearance and Handling of International Stores		CC	FS.1.1.1	HF.1.1.1.1	HP.1.1.1	HC.1.nec
2210	6	1	2	Port Health Establishment including Airport Organisation		CC	FS.1.1.1	HF.1.1.1.1	HP.6	HC.6.5.nec
2210	6	101	701	National Institute of Communicable Diseases		HK				
2210	6	101	3205	Drug Deaddiction Centre at AIIMS, New Delhi		CC	FS.1.1.1	HF.1.1.1.1	HP.1.2.1	HC.1.1.2
2210	6	101	34	National Mental Health Programme		CC	FS.1.1.1	HF.1.1.1.1	HP.6	HC.6.5.nec
2210	6	102	9	Food Safety and Standards Authority of India		CC	FS.1.1.1	HF.1.1.1.1	HP.6	HC.6.5.nec
2210	6	104	201	Central Drugs Standards Control Organisation (General Component)		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	6	104	5	Indian Pharmacopoeia Commission		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	6	104	6	National Pharmacovigi-lance Programme		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec

Major Head (Code) (1)	Sub Major Head (Code) (2)	Minor Head (Code) (3)	Sub Minor Head (Code) (4)	Description Sub Minor Head (5)	Expendi-ture (6)	CC/ HK (7)	FS (8)	HF (9)	HP (10)	HC (11)
2210	6	104	8	Strengthening of state drug regulatory system		HK				
2210	6	104	202	Central Drugs Standards Control Organization (Externally Aided Component)		CC	FS.2.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	6	106	1	BCG Vaccine Laboratory, Chennai		CC	FS.1.1.1	HF.1.1.1.1	HP.6	HC.6.2
2210	6	107	3	National Institute of Biological Standardization and Quality Control (Gen Component)		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	6	800	38	Anti micro resistance		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	2	1	501	Expenditure on Information, Education & Communication		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	2	200	29	National Mission on Medicinal Plants		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	2	200	30	Development of Ayush hospitals & Dispensaries and mainstreaming of Ayush		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2210	2	200	31	National Mission on AYUSH		CC	FS.1.1.1	HF.1.1.1.1	HP.7.1	HC.7.1.nec
2211		106	11	I.E.C.-Adolescent Health (RCH) (GC)		CC	FS.1.1.1	HF.1.1.1.1	HP.6	HC.6.1.nec
2211		109	09	Routine Immunisation Programme		CC	FS.1.1.1	HF.1.1.1.1	HP.6	HC.6.2
2211		200	02	Family Welfare Programme in other Ministries		CC	FS.1.1.1	HF.1.1.1.1	HP.3.4.1	HC.6.4
2211		200	04	Social Marketing of Contraceptives		CC	FS.1.1.1	HF.1.1.1.1	HP.3.4.1	HC.6.4

4.1.2 Health Expenditure by Other Union Ministries (non- employee)

There are other union ministries that spend on health through various programs. The significant ones given in **Table 4.5** are indicative due to changing health system context. NHA team should always improve upon this list

within preview of boundary of healthcare for India. Each of these programs and relevant healthcare expenditure are explained below. However certain programs such as Health Insurance will be dealt in detail in respective chapter.

Table 4.5: Programs of other Central Ministries/Departments for determining healthcare boundary

S.No.	Ministry	Department	Scheme
1	Labour and Employment	Labour and Employment	Social Security for Un-organized Sector Workers / Rastriya Swasthya Bima Yojana (RSBY)
			Working Conditions and Safety
			Labour Welfare Schemes
2	Youth Affairs and Sports	Youth Affairs and Sports	National Institute of Sports Science and Sports Medicine
3	Minority Affairs	Minority Affairs	Maulana Azad Medical Aid Scheme
4	Communication and Information Technology	Electronics and Information Technology	R&D in Medical Electronics and Health Informatics (erstwhile Electronics in Health & Telemedicine)
5	Finance	Revenue	Transfer to National Fund for control of drug abuse
6	Social Justice and Empowerment	Social Justice and Empowerment	Assistance for Prevention of Alcoholism and Substance (Drugs) Abuse
		Social Justice and Empowerment	Assistance to Voluntary Organisations for Old Age Homes.
		Disability Affairs	Artificial Limbs Manufacturing Corporation
		Disability Affairs	Aids and Appliances for the Handicapped
7	Women and Child Development	Women welfare	National Nutrition Mission
8	Atomic energy	Atomic Energy	Tata Memorial Centre
9	Chemical and Fertilisers	Pharmaceuticals	Jan Aushadhi Scheme
			National Pharmaceutical Pricing Authority

RSBY - Rashtriya Swastha Bima Yojana: Initiated by the Ministry of Labour and Employment, under the department of Labour and Employment.[31] The main objective of RSBY scheme is to provide the enrolled beneficiaries from the unorganized sector with a health insurance cover, thereby protecting them from the financial shocks arising out of an emergency medical situation. It aims to reduce the out- of-pocket expenses of the target population for every visit to hospital.

Working Conditions and Safety: Initiated by the Ministry of Labour and Employment,[32] funds are provided for Directorate General, Factory Advice Service and Labour Institutes which together are responsible for the safety, health and welfare of dock workers and factory workers. Provision has also been made for Directorate General of Mines Safety, who is responsible for the safety, health and working conditions of workers in coal and non-coal mines and oil fields. The programme objective is continuous reduction in the incidence of work-related injuries, fatalities, diseases, disasters and loss of national assets.

Labour Welfare Scheme[33]: Initiated by the Ministry of Labour and Employment, funds are provided for welfare schemes for Beedi Workers, labour working in Mica Mines, Iron, Chrome, Manganese Ore Mines (excluding coal mines workers), Limestone and Dolomite Mines Workers and Cine Workers. Expenditure is met out of cess levied and collected under the respective Labour Welfare Acts, which is transferred to Reserve Funds in the public account. The welfare schemes are for health, education, housing, recreation and water supply. Only health component needs to be extracted to find exact amount to be spent on health. The healthcare is provided through the enterprises hospitals/ clinics.

31 Rashtriya Swasthya Bima Yojana (RSBY) Operational Manual. Ministry of Labour and Employment. GoI.

32 http://labour.gov.in/upload/uploadfiles/files/Policies/SafetyHealthandEnvironmentatWorkPlace.pdf. Accessed on 14th August, 2015.

33 http://labour.nic.in/content/dglw/welcome.html#. Accessed on 14th August,2015.

Maulana Azad Medical Aid Scheme[34]**:** Initiated by the Ministry Of Minority Affairs, this scheme aims to provide healthcare to the minority community students, including preventive screening program as well as curative care (like surgeries, treatment of cancer along with minor ailments). These services will be provided through empanelled government hospitals. For the health centre at the education institute, the local doctor is available on call.

Health Insurance[35]**:** Initiated by the Ministry of Textiles, the Health Insurance Scheme (HIS) is one of the welfare schemes for handloom weavers implemented in collaboration with ICICI Lombard General Insurance Company Ltd. This scheme aims at financially enabling power loom workers/weavers to access the best of healthcare facilities in the country. The scheme covers hospitalization as well as OPD services through empanelled hospitals.

National Institute of Sports Science and Sports Medicine: Initiated by the department of Youth Affairs and Sport under the Ministry of Youth and Sports, the *objectives of the Institute are* Dissemination of information on Sports Science and Sports Medicine, Prevention, treatment and rehabilitation of sports injuries besides other non-health activities Allocation formula will be devised for separating health from non-health components.

R&D in Medical Electronics and Health Informatics[36]**:** Initiated by the Department of Electronics and Information Technology under the Ministry of Communication and Information Technology, its objective is to support and promote technology development and R&D in the area of medical electronics & health informatics.

Transfer to National Fund for Control of Drug Abuse[37]**:** Initiated by the Department of Revenue under the Ministry of Finance, it includes a provision for Central Bureau of Narcotics and Expenditure from the National Fund for Control of Drug Abuse (NFCDA). Expenditures for activities such as identifying, treating, and rehabilitating addicts and supplying drugs to addicts where such supply is medical necessity, are included as health expenditures

Assistance for Prevention of Alcoholism and Substance (Drugs) Abuse[38]**:** Initiated by the Ministry of Social Justice and Empowerment the scheme is being implemented for identification, counselling, treatment and rehabilitation of addicts through Voluntary Organizations. The part of the scheme that deals with medical rehabilitation is included in health expenditures.

Artificial Limbs Manufacturing Corporation:[39] Initiated by the Ministry of Social Justice and Empowerment under the Department of Disability Affairs, Artificial Limbs Manufacturing Corporation of India (ALIMCO) is a non-profit making organization. It manufactures and supplies artificial limb components and rehabilitation aids for the benefit of the physically handicapped.

The mission of the ALIMCO is the empowerment of persons with disabilities and restoration of their dignity by way of manufacturing and supplying durable, sophisticated, scientifically manufactured modern and ISI standard quality assistive aids. Thus, it is included in the healthcare expenditure boundary.

Aids and Appliances for the Handicapped[40]**:** Initiated by the Ministry of Social Justice and Empowerment, the objective of the scheme is to provide Grants-in-aid to various implementing agencies to assist needy and disabled persons in procuring durable, sophisticated and scientifically manufactured, modern, standard aids and appliances that can promote their physical, social and psychological rehabilitation. The part related with the medical rehabilitation of the handicapped, will be inside the boundary of healthcare expenditure.

34 http://www.jass.in/pdf/sehat_scheme.pdf Accessed on 14th August, 2015.

35 http://218.248.11.68/textilehandloom/pdf/Health_Insurance_Scheme.pdf Accessed on 14th August, 2015

36 http://deity.gov.in/content/medical-electronics-health-informatics-telemedicine-applications. Accessed on 14th August, 2015

37 http://dor.gov.in/national_%20fund_control_drugsabuse Accessed on 14th August, 2015

38 http://socialjustice.nic.in/pdf/drugsabuse.pdf Accessed on 14th August, 2015

39 http://www.alimco.in/content/13_1_MissionandVisionofALIMCO.aspx. accessed on 14th August, 2015

40 http://socialjustice.nic.in/pdf/adipscHPdf accessed on 14th August, 2015.

Tata Memorial Centre (TMC): Initiated by the Ministry of Department of Atomic Energy, TMC is an advanced center for treatment, research and education in cancer (ACTREC). Hence, while the treatment part will be included in current health expenditures, research and education will be included as capital expenditures.

Jan Aushadi Scheme: Initiated by the Department of Pharmaceuticals under the Ministry of Chemicals & Fertilisers, the objective is to ensure access to quality medicines through the CPSU supplies and through GMP Compliant manufacturers in the private sector. It extends coverage of quality generic medicines at affordable prices for all with the goal of improving affordable quality healthcare. Hence, it is included inside the boundary.

National Pharmaceutical pricing Authority (NPPA)[41]: As a part of the new Drug Policy announced in September, 1994, an independent body of experts has been setup, which is responsible for price fixation/revision of drugs and formulations and other related matters. It also monitors the prices of decontrolled drugs / formulations and oversees the implementation of the provisions of Drugs (Price Control) Order.

National Nutrition Mission: Initiated by the Department of Women Welfare under the Ministry of Women and Children is a multi-sectoral nutrition programme to address Maternal and Child Under-Nutrition which aims at prevention and reduction in child under-nutrition and reduction in levels of anaemia among young children, adolescent girls and women. The program also includes Information, Education and Communication (IEC) campaign against malnutrition: To create awareness about nutrition challenges and promote home-level feeding practices. There are two components of the programme, namely health and non-health component. The health component of the programme is taken care of by the Ministry of Health and Family Welfare.

Table 4.6: Mapping other Union Ministry health expenditure to SHA 2011 framework and classifications

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.1.1.1.1 Union government schemes (Non-Employee)
Revenue of the financing scheme (FS)	FS.1.1.1 Internal transfers and grants – Union Government
Healthcare Providers (HP)	HP.1.1.1 General Hospitals -Government
	HP.1.3.1 Specialised hospitals- Government
	HP.3.4.9 All other ambulatory centres- Government
	HP.6 Providers of preventive services
	HP.7.1 Government health administration agencies
Healthcare Functions (HC)	HC.1.1.1 Inpatient curative care - general
	HC.1.1.2 Inpatient curative care –specialized
	HC.1.3.1 Outpatient curative care – general
	HC.1.3.3 Outpatient curative care -specialized
	HC.2.1.nec rehabilitative care
	HC.6.1.nec Information, education and counselling programmes
	HC.6.2 Immunisation programmes
	HC.6.3 Early disease detection programmes
	HC.6.4 Healthy condition monitoring programmes
	HC.6.5.nec Epidemiological surveillance and risk and disease control programmes
	HC.6.6 Preparing for disaster and emergency response programmes
	HC.7.1.nec Governance and Health system administration
	HC.7.2 Administration of health financing

41 http://indiabudget.nic.in/ub2015-16/eb/sbe9.pdf. Accessed on 26/11/15

4.1.2.1 Data sources

Table 4.7: Data sources Union Government – other ministries

Sources of Expenditure Ministry/ Department	Data source
Ministry of Communication and Information Technology	DDG Demand No. 13- Dept. of Posts DDG Demand No. 18 – Dept. of electronics and information technology
Ministry of Mines	DDG Demand No. 67
Ministry of Railways	DDG- Part-I & Part-II
Ministry of Science and Technology	DDG Demand No. 86- Dept. of Science and Technology DDG Demand No. 87- Dept. of Scientific and Industrial Research DDG Demand No. 88- Dept. of Bio-Technology
Ministry of Defence	Defence Services Estimates
Ministry of Labour and Employment	DDG Demand No. 62
Ministry of Minority Affairs	DDG Demand No. 68
Ministry of Youth Affairs and Sports	DDG Demand No. 109
Ministry of Finance	DDG Demand No. 43- Department of Revenue
Ministry of Social justice and Empowerment	DDG Demand No. 90
Ministry of atomic energy	DDG Demand No. 4
Ministry of chemicals and Fertilisers	DDG Demand No. 9- Dept. of Pharmaceuticals

4.1.2.2 Mapping and classifications

According to SHA 2011, these schemes are classified and coded as given in **Table 4.8**. Each expenditure line item is mapped to different codes

Table 4.8: Mapping other union ministries (non-employee) expenditures to SHA 2011 classification and codes

Ministry/ Department	Major Head	Sub Major Head	Minor Head	Sub Minor Head	Detailed Head	HK/ CC	FS	HF	HP	HC
Labour and Employment	2230	102	8	24	Strengthening of Directorate General of Factory Advice Services (DGFASLI) Organisation and occupational safety and health in factories ports and docks	CC	FS.1.1.1	HF.1.1.1.2	HP.7.1.nec	HC.7.1.nec
	2230	102	1	105.02	Mica Mines Labour Welfare – Health	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.2	HC.1.1.1
Minority Affairs	2225	277	4	10	Maulana Azad Medical Aid Scheme	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.2	HC.1.1.2
Finance	2070	0.113		4	Expenditure on Control of Drug Abuse	CC	FS.1.1.1	HF.1.1.1.2	HP.6	HC.6.1.nec
Social Justice and Empowerment	2235				Assistance for Prevention of Alcoholism and Substance (Drugs) Abuse	CC	FS.1.1.1	HF.1.1.1.2	HP.6	HC.6.1.nec
Atomic Energy	3401				Tata Memorial Centre, Mumbai	CC	FS.1.1.1	HF.1.1.1.2	HP.1.3.1	HC.1.1.2
Chemicals and Fertilizers	2852				Jan Aushadhi Scheme	CC	FS.1.1.1	HF.1.1.1.2	HP.7.1	HC.7.1.nec
Mines	2.06				National Institute of Miner's Health	HK				
Posts	3				Dispensaries (Sub-Head)	CC	FS.1.1.1	HF.1.1.1.2	HP.3.4.9	HC.1.3.1
Biotechnology	2				Autonomous R&D Institutions (Scientific Institutions/ Professional Bodies)	HK				

4.1.3 Health expenditure by union government (employee)

Union governments covers medical expenses of its employees, pensioners and their dependents through reimbursement of medical bills or financing social health insurance contributions (CGHS, ECHS, CHSS and RELHS) providing care through their own network of health facilities and empanelled public or private providers.

Government finances contributions to social health insurance schemes such as CGHS, ECHS, CHSS and RELHS. The detailed explanation of these financing schemes and revenue of financing schemes with their providers and functions are discussed in the chapter on Health Insurance.

Besides the above, Union Government employees are covered for their medical expenses through following schemes.

Civil Services Medical Attendance (CSMA): the medical expenses of union government employees or the civil employees and their dependents (other than those of the railways and defence schemes; and those residing in non-Central Government Health Scheme area) are reimbursed by the government through their own ministries/departments under the CSMA. This is a non-contributory scheme and entirely funded by the union government of India as an employment benefit. Under CSMA the employees are directly reimbursed the medical bills or reimbursements are made to empanelled government and private hospitals and medical practitioners.

Defence Health Services: Union Ministry of Defence finances healthcare of its current employees and their dependents from its own budget under the Armed Forces Medical Services (AFMS). It has a network of health facilities across India exclusively for its own employees. These are called the defence clinics and hospitals.

Railway Health Services: The ministry of railways finances healthcare of its employees, pensioners and their dependents from its own budget. It has a network of health facilities across India to deliver outpatient and inpatient services.

4.1.3.1 Data sources

Table 4.9: Data sources Union Government – other ministries

Ministry of Railways	DDG- Part-I & Part-II. This is inclusive of social health insurance scheme for railway pensioners and dependants as the budget does not differentiate between the both
Ministry of Defence	Defence Services Estimates. These have to be net of expenditures on Ex-Servicemen Contributory Health Scheme (ECHS) also implemented by MoD.
CSMA	Part of the medical treatment detailed head(06) of all the DDG of all the Ministries / Departments. These are disaggregated using the pro-potion of civil service employees getting this benefits from those receiving it through Central Government Health Scheme (CGHS). The total expenditure on medical treatment detailed head is also available from Controller General Accounts (CGA). Thus this apportionment has to be made by the NHA team according to the financial year chosen
All other Ministries/ Departments	DDGs for respective Ministries/ Departments

4.1.3.2 Mapping and classification

According to SHA 2011, these schemes are classified and coded as given in **Table 4.10**. Each expenditure line item is mapped to different codes

Table 4.10: Mapping union ministries (employee) expenditures to SHA 2011 classification and codes

Medical Services	CC/HK	FS	HF	HP	HC
Railways					
Control and Superintendence at Headquarters and Divisions	CC	FS.1.1.1	HF.1.1.1.2	HP.7.1	HC.7.1.nec
Hospital and Dispensaries excluding cost of Medicine	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1 |HP.3.4.9	HC.1.1.1| HC.1.1.3
Cost of Medicines	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1, HP.3.4.9	HC.1.1.1| HC.1.1.3
Reimbursement of medical expenses and miscellaneous	CC	FS.1.1.1	HF.1.1.1.2	HP.10	HC.9
Public Health	CC	FS.1.1.1	HF.1.1.1.2	HP.6	HC.6.1.nec
Maintenance of equipment - Medical Department	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1	HC.1.1.1
Defence					
Pay & Allowances of the Army Medical Corp. Army Dental Corps and other Nursing Services including personal in the Navy and the Air Force and at the Headquarters	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1| HP.3.4.9	HC.1.1.1| HC.1.3.1
Pay & other miscellaneous expenses of Medical Units of the territorial Army.	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1 |HP.3.4.9	HC.1.1.1| HC.1.3.1
Civilian staff at the Headquarters and in Hospital, Medical Estt. Etc.	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1| HP.3.4.9	HC.1.1.1| HC.1.3.1
Conveyance of personal	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1	HC.1.1.1
Miscellaneous expenses of Hospital and other Medical Establishments	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1	HC.1.1.1
Medical Stores	CC	FS.1.1.1	HF.1.1.1.2	HP.1.1.1, HP.3.4.9	HC.1.1.1| HC.1.3.1
CSMA (civil servants medical attendance by all ministries/departments)	CC	FS.1.1.1	HF.1.1.1.2	HP.10	HC.9

4.1.3.3 Allocation keys for Union Government expenditures

Whenever there are multiple classification codes for a expenditure line item, expenditures against it are to be apportioned among the related classification codes. The specific proportions for allocations are to be arrived from scheme related information, e.g. HMIS data or literature search, costing studies etc. Items in **Table 4.11** have been allocated as per CGHS data[42].

Table 4.11: Apportioning proportions for the line items of Union Ministry

Ministry	Expenditure Line item	HP	HC
Railways	Hospital and Dispensaries excluding cost of Medicine	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (65%) HP.3.4.9 (35%)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
	Cost of Medicines	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (52%) HP.3.4.9 (48%)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
Defence	Pay & Allowances of the Army Medical Corp. Army Dental Corps and other Nursing Services including personal in the Navy and the Air Force and at the Headquarters	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (65%) HP.3.4.9 (35%)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
	Pay & other miscellaneous expenses of Medical Units of the territorial Army.	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (65%) HP.3.4.9 (35%)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1

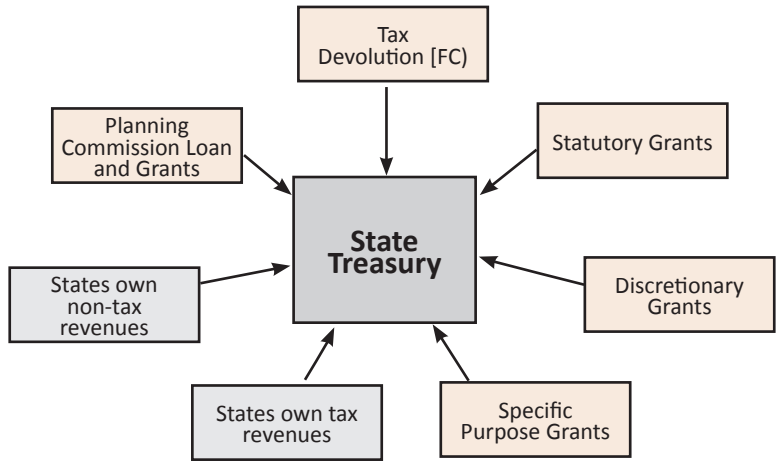
42 The allocation for cost of medicine is derived using the data for CGHS in 2013-14. 65% of the expenditures were incurred in hospital and 35% were incurred in dispensaries. 28% of expenditures under hospitals and 48% of expenditures under dispensaries were spent on medicines.

Ministry	Expenditure Line item	HP	HC
	Civilian staff at the Headquarters and in Hospital, Medical Estt. Etc.	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (65%) HP.3.4.9 (35%)[43]	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
	Miscellaneous expenses of Hospital and other Medical Establishments	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (65%) HP.3.4.9 (35%)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
	Medical Stores	HP.1.1.1 HP.3.4.9 Expenditure is allocated HP.1.1.1 (52%) HP.3.4.9 (38%)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
MoHFW	Medical Store Depot	HP.1.1.1 HP.3.4.9 allocation to be made using information from facility wise distribution of drugs cost e.g. TNMSC and RMSC (passbook data)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1
	Purchase of Material from Abroad	HP.1.1.1 HP.3.4.9 allocation to be made using information from facility wise distribution of drugs cost e.g. TNMSC and RMSC (passbook data)	HC.1.1.1, HC.1.3.1, HP.1.1.1 allocated to HC.1.1.1 HP.3.4.9 allocated to HC.1.3.1

4.2 State Government Health Expenditure

The states are largely independent in matters relating to the delivery of healthcare to the people. Each state has developed its own system of healthcare delivery, independent of the central government. However, they receive funds from central government and also implement some of the central government programs. The sources of revenues for the state government are shown in **Figure 4.3**

Figure 4.3: Revenue generation –State Government[44]



Abbreviations: FC=Finance Commission

43 Assumed that the expenditure on dispensaries established to provide outpatient care and referral services to the beneficiary will be proportional to CGHS spending on dispensaries operated for similar purpose. CGHS spending on dispensaries is 35% of the total CGHS expenditures. Assuming that similar scenario will be in railways and Defence.

44 The Planning commission has been replaced by NITI Aayog from 1st January, 2015 (The cabinet secretariat vide Resolution No. 511/2/1/2015- Cab. Dated January 1st, 2015.

Within the state Government there is department of health and family welfare and several other departments that spend on the healthcare of the employee, their dependents or general population. The health expenditures by other state government departments are described in details in the next section. The DDGs of all the departments were screened to identify heads under which health expenditure had happened and all the relevant data was entered. Three different sets of information available from the DDGs of all the government departments with health expenditures are

1. Major Heads reflected in the DDG of State Department of Health and Family Welfare
2. Major Heads under which different departments of the state have incurred expenditures on health (as described in the section on boundaries), and
3. Major Heads under which respective departments have paid medical bills of the state government employees in the form of medical reimbursements

4.2.1. Health expenditure by the state department of health and family welfare (non-employees)

The State Government has both independent responsibilities as well as shared responsibilities with the central government. The responsibility of following functions of the State Government are shared with the central government and are laid out in the seventh schedule of the Indian Constitution, in the 'Concurrent List'/ 'List III'[45]: 1. Prevention and control of communicable diseases. 2. Prevention of adulteration of foodstufFS.3. Control of drugs and poisons. 4. Vital statistics. 5. Economic and social planning. 6. Population control and Family Planning 7. Preparation of health education material for creating health awareness through Central Health Education Bureau. 8. Collection, compilation, analysis, evaluation and dissemination of information through the Central Bureau of Health Intelligence and 9. National Medical Library.

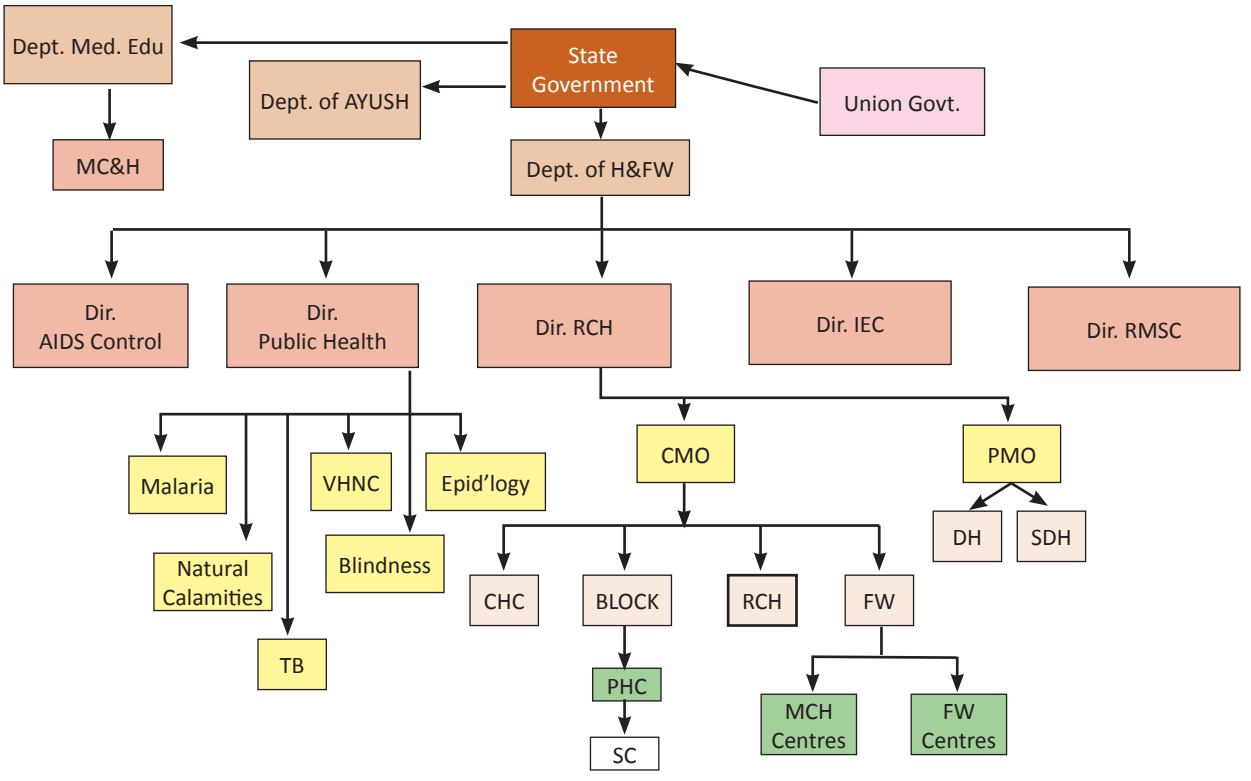
The independent responsibilities of the State pertaining to health as per the Constitution of India (as mentioned in the Schedule Seven – State List/List II) are as follows: 1. Study the health problems and needs in the state and plan schemes to solve the problems. 2. Provision of curative & preventive services. 3. Provision for control of milk and food sanitation. 4. Prevention of any outbreak of communicable diseases. 5. Promotion of health education. 6. Promotion of health programmes such as school health, family planning, Occupational health, etc. 7. Supervision of public health facilities. 8. Establishing training courses for health personnel. 9. Co-ordination of all health services with other state departments such as department of education, etc. 10. Establishment and maintenance of medical institutions with necessary infrastructure.

To provide preventive, promotive and curative Health Services to the people, every state has established a network of medical institutions such as sub-centers, subsidiary health centers (dispensaries/Clinics etc.), primary health centers, community health centers, Sub-Divisional and District Hospitals, Government Medical & Dental Colleges (attached hospitals). These health facilities provide services that are predominantly fully subsidized. Several services are also provided under the public private partnership mode, where contractual arrangement of different type is set between the public and private sector.

To execute all the above-mentioned functions through the public healthcare delivery system in a state, the health department gets funds from the Union government, State Government and from the foreign aid agencies (via Union or State Government) through budgetary provisions. The Department of Health and Family Welfare receives these funds under the plan and non-plan outlay for recurrent/ operational expenditures and capital expenditures. The department also receives funds from Union Government in the form of Grant-In-Aid and funds for centrally sponsored schemes. These funds are allocated further to the administrative heads of different public health facilities within the state. The flow of funds is explained in detail in **Figure 4.4.**

45 The Constitution of India provides for a division of powers between the Union (Centre) and states. It divides all the subjects into 3 lists - Union List, State List and Concurrent List. The Concurrent List describes the subjects that are under the joint jurisdiction of the Centre and States.

Figure 4.4: Flow of funds[46]



Abbreviations: H&FW=Health and Family Welfare; AYUSH=Ayurveda Yoga Unani Siddha Homeopathy; MC&H=Medical College and Hospital; RCH=Reproductive and Child Health; IEC=Information Education and Communication; RMSC=Rajasthan Medical Services Corporation; TB=Tuberculosis; VHNC=Village Health and Nutrition Committee; CMO=Chief Medical Officer; PMO=Principal Medical Officer; CHC=Community Health Centre; RCH=Reproductive and Child Health; FW=Family Welfare; DH=District Hospital; SDH=Sub-District Hospital; PHC=Primary Health centre; MCH=Mother and Child Health Centres; FW=Family Welfare centres; SC=Sub Centres

Every State Government has its own programs based on its specific requirements, in addition to the national programs that are implemented through the healthcare facilities owned and administered by the state government.

The public health system at the state level is expected to ensure access to basic healthcare for the whole society, a large part of it or at least some vulnerable groups. In most of the Indian states, basic healthcare in a government health facility is free for poor (BPL-Below the Poverty Line) and highly subsidized for rest of the people who seek care through the public health system. The schemes at state level can be further divided into Government Schemes and compulsory contributory health insurance schemes as per the SHA 2011 framework. At the state level, all the central government schemes as well as the states own schemes are operational through the public health system. The only exceptions are services that are provided through a Public Private Partnership (PPP) mode. Under PPP mode the State or Central Government engages a private provider through a contractual arrangement for provision of specific services such as patient transport, diagnostics/ laboratory and imaging services, laundry and linen, etc. or outsource entire health facility or a group of health facilities to the private provider. The Government provides operational cost for provision of such services to the private provider. According to SHA 2011, the schemes are classified and coded as shown in **Table 4.12.**

46 *Note: Flow of Funds is represented taking an example of the Rajasthan State Department of Health and Family Welfare.*

Table 4.12: Identifying state government health expenditure to SHA 2011 framework classifications and codes

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.1.1.1.1 Union government schemes (Non-Employee)
	HF.1.1.2.1 State government schemes (Non-Employee)
Revenue of the financing scheme (FS)	FS.1.1.1 Internal transfers and grants – Union Government
Institutional unit and financing agent	FS.1.1.2 Internal transfers and grants – State Government
	FS.2.2 Transfers distributed by State government from foreign origin
Healthcare Providers (HP)	HP.1.1.1 General Hospitals -Government
	HP.1.2 Mental health hospitals- Government
	HP.1.3.1 Specialised hospitals – Government
	HP.3.3 Other healthcare practitioners- Government
	HP.3.4.1 Family planning centres- Government
	HP.3.4.9 All other ambulatory centres- Government
	HP.4.1 Providers of patient transportation and emergency rescue
	HP.6 Providers of preventive services
	HP.7.1 Government health administration agencies
Healthcare Functions (HC)	HC.1.1.1 Inpatient curative care - general
	HC.1.1.2 Inpatient curative care –specialized
	HC.1.3.1 Outpatient curative care – general
	HC.1.3.2 Outpatient curative care -Dental
	HC.1.3.3 Outpatient curative care -specialized
	HC.2.nec rehabilitative care
	HC.3.nec Long term care
	HC.4. 3 Patient transportation
	HC.6.1.nec Information, education and counselling programmes
	HC.6.2 Immunisation programmes
	HC.6.3 Early disease detection programmes
	HC.6.4 Healthy condition monitoring programmes
	HC.6.5.nec Epidemiological surveillance and risk and disease control programmes
	HC.6.6 Preparing for disaster and emergency response programmes
	HC.7.1.nec Governance and Health system administration
	HC.7.2 Administration of health financing
	HC.9 Other healthcare services not elsewhere classified (nec)
	HC.RI.1 Total pharmaceutical expenditure
	HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

4.2.1.1 Data sources

The main data source for the State Government Department of Health expenditures is the DDG of Department of Health and family welfare.

4.2.1.2 Boundaries

All line items that are included in the state department of Health and Family welfare and shown in the flow of funds diagram and are part of health expenditures. Few items excluded from the state treasury budget of the Rajasthan Department of health and Family Welfare (based on the set criteria defined in SHA 2011 framework) is

1. Compensation for wage loss (for adopting family planning),
2. Compensation for failure of sterilization and
3. Maternity benefits (Salaries of staff on maternity leave)

Likewise any state DOHFW budgets must also be screened for any such exclusions not fulfilling the boundary criterion of primary purpose being for health, transactions are for final consumption of healthcare goods and services and medical knowledge is used.

4.2.1.3. Mapping and Classification

This section deals with the mapping of expenditure line items of each state government scheme to SHA 2011 classification and development of allocation keys.

Expenditure line items for each state government (DoHFW) are first segregated into "current" and "capital" consumption in the manner as described below

Expenditure line items for each State Government (DoHFW) health scheme are sourced from the data sources mentioned in the scheme description. The SHA 2011 framework requires capital expenditure to be separated from the current expenditure as all investments in the health sector (for e.g. Construction of buildings, medical education, research etc.) that will be consumed for a longer duration are treated separately and will be explained in greater details in the chapter on "Capital Formation". Thus, to begin with, the healthcare consumption expenditure has to be first divided into current and capital expenditure. This can be done at two levels for the state government health expenditures. Firstly at the level of major heads where the major heads like 4210 and 4211 can be directly considered as "capital" expenditure.[47] Secondly, within the major heads 2210 and 2211, at the level of sub minor head (the heads/ line items used for classification) all line items reporting capital expenditure should identified and separated from current consumption expenditure. For e.g. the line items pertaining to medical education, training and research components that appear under the major head 2210 are separated from current consumption since expenditure on medical education, training and research (as per the SHA 2011 manual) should be treated as "capital" expenditure.

State governments also follow a similar way of functioning as union government when it comes to the budgetary system. As mentioned earlier state government has the flexibility to open up codes after the third level i.e. at the level of sub-minor head as per their specific needs. This is one of the reasons why the health department DDG of different states do not look completely similar in terms of the line items, but it is worth noting that the theme/ scheme of the head remains same as it is a sub head of a minor head which represents the basic nature of a scheme. Since variations are observed prima face, it is important to note that the actual classification of current expenditure should be done at the level of sub-minor head of budgetary coding, as the scheme description at this level is the most appropriate for SHA 2011 classification. At any point where information is not sufficient or there is any difficulty in decision-making, it would be beneficial to refer to the previous or later budgetary codes.

The DDGs Sheet for state government expenditure line items and mapping to SHA 2011 codes is shown in **Table 4.13** Column 1. Major Head, Column 2. Sub Major Head, Column 3. Minor Head, Column 4. Sub Minor Head, Column 5. Description of Sub Minor Head (expenditure line item), Column 6. Expenditure, Column 7. Current (CC) or Capital (HK) expenditure is indicated, Column 8. Classification of Revenues of Financing Schemes (FS), Column 9. Classification of Financing Scheme (HF), Column 10. Classification of Healthcare Providers (HP), Column 11. Classification of Healthcare Functions (HC). Hence Columns 1-6 are directly taken from the DDG and columns 7-11 are created for SHA classifications.

47 Controller General of Accounts (CGA) defines the Major, Minor and Sub-Heads with respective codes and the same are followed by the Union and State Government in the budget books.

Table 4.13: State department of health and family welfare budget classification and mapping

Major Head (Code)	Sub Major Head (Code)	Minor Head (Code)	Sub Minor Head (Code)	Description Sub Minor Head	Expendi-ture	CC/ HK	FS	HF	HP	HC
2210	01	001	01	Urban Health Services- Allopathy- Direction & Administration- Establishment of Head Quarters		CC	FS.1.1.2	HF.1.1.2.1	HP.7.1	HC.7.1
2210	01	001	02	Establishment of District and regional areas		CC	FS.1.1.2	HF.1.1.2.1	HP.7.1	HC.7.1
2210	01	104	01	Medical Stores Depot		CC	FS.1.1.2	HF.1.1.2.1	HP.1.1.1, HP.3.4.9	HC.1.1.1, HC.1.3.1
2210	01	110	001-1	Hospitals and Dispensaries- Teaching Hospitals- J.L. Nehru Hospital, Ajmer		CC	FS.1.1.2	HF.1.1.2.1	HP.1.1.1	HC.1.1.2
2210	01	110	001-6	G.G.J. T.B. Hospital, Bikaner		CC	FS.1.1.2	HF.1.1.2.1	HP.1.3.1	HC.1.1.2
2210	01	110	001-7	Mental Hospital, Bikaner		CC	FS.1.1.2	HF.1.1.2.1	HP.1.2	HC.1.1.2
2210	01	110	001-9	Rehabilitation Research Centre, Jaipur		CC	FS.1.1.2	HF.1.1.2.1	HP.1.3.1	HC.2.nec
2210	01	110	001-12	Contagious Disease Hospital, Jaipur		CC	FS.1.1.2	HF.1.1.2.1	HP.1.3.1	HC.1.1.2
2210	01	110	001-14	Sir Padam Pat Maternity and Child Health Institute, Jaipur		CC	FS.1.2.2	HF.1.1.2.1	HP.1.3.1	HC.1.1.2
2210	01	110	002-3	Mobile Hospital, Ajmer		CC	FS.1.1.2	HF.1.1.2.1	HP.1.1.1	HC.1.1.1
2210	01	110	003-7	Control of diseases due to natural calamities		CC	FS.1.1.2	HF.1.1.2.1	HP.6	HC.6.6
2210	01	197	002-1-3	Primary Health Centres		CC	FS.1.1.2	HF.1.1.2.1	HP.3.4.9	HC.1.3.1
2210	01	796	05	Community health center		CC	FS.1.2.2	HF.1.1.2.1	HP.1.1.1	HC.1.1.1, HC.1.3.1
2210	02	101	002-1	Hospitals & Dispensaries- Ayurveda		CC	FS.1.1.2	HF.1.1.2.1	HP.1.3.1	HC.1.1.1, HC.1.3.1
2210	02	101	005-02	Rasayan Shalain (Medicine Centres)		CC	FS.1.1.2	HF.1.1.2.1	HP.1.3.1	HC.1.nec
2210	03	101	01	Rural Health Services- Allopathy- Health Sub-Centre		CC	FS.1.1.2	HF.1.1.2.1	HP.3.3	HC.6.2, HC.6.1, HC.6.3, HC.6.4, HC.6.5.nec
2210	06	101	01	Prevention and Control of diseases- National Eradication Programme for Malaria		CC	FS.1.1.2	HF.1.1.2.1	HP.6	HC.6.5.nec
2210	06	102		Prevention of Food Adulteration		CC	FS.1.1.2	HF.1.1.2.1	HP.6	HC.6.5.nec
2210	06	107	01	Public Health Laboratories		CC	FS.1.1.2	HF.1.1.2.1	HP.6	HC.6.5.nec
2210	05	105	01-12	Dental College, Jaipur		HK				
2210	05	105	01-02	Medical College, Bikaner		HK				

4.2.1.4. Methodology to estimate some line items and development of allocation keys

Expenditures reported in the data sources when mapped against the SHA 2011 classifications might have multiple revenue sources, healthcare providers and healthcare functions requiring a given line item's expenditures to be apportioned or split among the related classification codes. Arriving at proportions of these splits is called development of allocation keys. Such splits under any of the classification can be arrived from the existing data sources. These have to be carefully considered through literature search on the related subject or by taking expert opinion. In case of the splits are not available, a research study conducted on a sample of these providers, might be beneficial.

In case of government expenditures the allocation keys have to be carefully formulated and should be based on secondary data such as NSSO health round data or robust costing studies. One may also make use of management information data/ utilization data for caseloads, but this data should be used in combination with the costing data and not as a direct proxy. **Table 4.14** provides the allocation keys for the provider data by healthcare functions – inpatient and outpatient care.

Table 4.14: State department of health and family welfare budget allocation keys[48] [49]

S.no	Expenditure Line item	HC	Allocation Keys*
1.	District Hospital	HC.1.3.1, HC.1.1.1	Can be allocated into 1: 2.9[50]
2.	Sub District Hospital	HC.1.3.1, HC.1.1.1	Can be allocated into 1:3.2*
3.	Community Health Centre	HC.1.3.1, HC.1.1.1	Can be allocated into 1:0.41
4.	Primary Health Centre	HC.1.3.1, HC.1.1.1	Can be allocated into 1: 0.18
5.	Sub Centers	HC.6.2, HC.6.4, HC.6.5	Can be allocated between HC.6.2 (6%), HC.6.4 (82%) and HC.6.5 (12%)
6.	Medical Stores depot	HC.1, HC.2, HC.6	By using Passbook data of TNMSC and RMSC

** These allocation keys are only indicative and can change based on the specific study in the state for a given year.*

Hospitals and dispensaries

Using the information on expenditures from drawing and disbursing officers from three states (viz. Karnataka, Rajasthan and Assam) the proportions of funds withdrawn by DDOs at healthcare facilities (viz. DH, SDH, CHCs and PHCs) under the line item hospitals and dispensaries have to be allocated as 97.34 per cent to Hospitals and 2.66 per cent to dispensaries and should be classified accordingly. The provider and functional classification for hospitals is HP.1.1.1 and HC.1.1.1 and the same for dispensaries is HP.3.4.9 and HC.1.3.1.

The allocations keys for inpatient and outpatient have been arrived at, by taking HMIS data for caseloads at a facility along with the cost ratio of providing inpatient and outpatient services at these facilities using the following formula:

- Case load ratio at the facility = IPx /OPx,
- Costing Ratio at the facility = IPc/ OPc
- Total expenditure ratio IP/ OP = (IPx/ OPx)*(IPc /OPc)

Where, IPx = cases of in-patient at facility, OPx = cases of out -patient at facility, IPc = Average cost of 1 Inpatient, OPc = Average cost of 1 outpatient, IP = In-patient, OP = Outpatient.

These ratios will vary across states depending on the costs and utilisation of different services.

48 These allocation keys are for the state of Rajasthan. The HMIS data is available facility wise for all states and will be used accordingly for each state; however the cost ratio was available only for public facilities in Punjab and Haryana. Due to unavailability of data from other states, for NHA 2013-14, same cost ratio across all the states was used. Cost for SDH has been taken similar to the DH, because of unavailability of the data for the same.

49 http://www.pbnrhm.org/downloads/201-300_Beded_District_Hospitals.pdf. P.9.

50 http://www.pbnrhm.org/downloads/201-300_Beded_District_Hospitals.pdf. P.9.

Sub-Centres

The expenditure under sub-centres are primarily for HC.6 Preventive care and can be allocated on the basis of utilization of activities done and human resource cost of each activity. Based on the costing study by PGIMER Chandigarh, the allocation of expenditure line items specifying Sub-centres can be made based on the costs only. The major activities are ANC, PNC, immunization and DOTS service. Assuming that these are the only activities that happen at the Sub-centre, the total cost of these four activities can be treated as the total expenditure at the SC. Hence the expenditure ratios can be directly applied. The costs for each of these activities are as follows:

Sr. No	Activity	Unit Cost (Rs.)	Percentage Allocation	Classification Code
1	ANC	525	33%	HC.6.4
2	PNC	767	49%	HC.6.4
3	Immunization	97	6%	HC.6.2
4	DOTS	187	12%	HC.6.5
	Total	1576		

Therefore the allocation keys for functional classification are as follows:

Classification Code	Percentage Allocation
HC.6.2	6%
HC.6.4	82%
HC.6.5	12%

These allocation keys are only indicative and can change based on the specific study in the state for a given year.

Medical Store Depot

Medical store depots are the institutions that manage the logistics and supply chain of medicines, drugs and consumables in a state. It includes cost of procurement of medicines, drugs and consumables and the administrative cost. We consider all the expenditure as expenditure on medicines, drugs and consumables and do not separate the administrative cost. These drugs are distributed to different facilities as per the demands put up by respective facilities.

Hence while doing the provider classification the total expenditure on medical stores depot is to be allocated into different providers such as Hospitals, dispensaries and other ambulatory care centres. The best method for allocation is using the passbook data from TNMSC or RMSC, where facility wise total demand (quantity), unit cost and total expenditure is provided. These proportions worked out as 45% to medical colleges' hospitals, 45% to general hospitals (including DH, SDH, and CHC) and 10% to PHC.and dispensaries. Same proportions can be used for allocation across states if data from passbooks are not available.

AYUSH Hospitals and Dispensaries

The line item that reads AYUSH Hospitals and Dispensaries includes expenditure on both AYUSH Hospitals and AYUSH dispensaries. Ideally these two should be separated and classified accordingly. But due to unavailability of data all expenditure under this line item will be classified as dispensaries i.e. Provider Classification – HP.3.4.9 and Functional Classification –HC.1.3.1

HC.RI.1 Total Pharmaceutical Expenditure

The detail demand for grants for state department of health and family welfare have object heads for drugs and consumables. Some states have a separate object head "Drugs and consumables", while others have object head "materials and supplies" which includes expenditure on drugs and consumables. These object heads fall under different sub minor heads and need to be culled out and added to get the total expenditure

on drugs and consumables by the state department of health and family welfare. This total is reported as HC.RI.1. For states that have only one object head i.e. "materials and supplies" and no other specific object head for "drugs and consumables", in such cases the expenditure on drugs and consumables have to be separated from the expenditure on materials and supplies. For doing this one needs to either do a literature search or conduct a study to understand what proportion of the total expenditure on "materials and supplies" is spent on buying drugs and consumables. The third option is to assume all expenditure on "materials and supplies" happens only on buying drugs and consumables and mark all the expenditure as HC.RI.1 Total Pharmaceutical Expenditure. Another category in which drugs appear under the object heads in the budgets are "Medical Care Good" which include medicines and healthcare related goods. An indicative break up of medical care goods into drugs and other healthcare related products is 7.2:1.2 from Tamil Nadu Medical Services Corporation data for 2013-14. The total HCR1 data derived from all the object heads can further be divided into HC.RI.1.1 of which inpatient and HC.RI.1.2 of which outpatient, applying the same allocation formula used for separating inpatient and outpatient in hospitals and dispensaries (as mentioned earlier in this section).

HC.RI.2 Traditional Complementary and Alternative Medicine (TCAM)

In many states in India AYUSH is a separate department and hence has a separate detail demand for grants with a separate demand number. All expenditures under the DDGs of AYUSH department should be marked as HC.RI.2.

The DDGs of department of health and family welfare of all the states also have two sub major heads that report expenditure on TCAM or AYUSH (in the Indian context). These sub major heads are, "02 – Urban Health Services Other Systems of Medicine" and "04 – Rural Health Services Other Systems of Medicine". All line items under these two sub major heads should be marked as HC.RI.2.

In addition to this the states also spend on mainstreaming of AYUSH under the National Health Mission (FMR Code: B.9) and also on AYUSH doctors (FMR code: A.8 – Human Resources). These expenditures also should be marked as HC.RI.2.

All expenditures under the above mentioned line items should be added together to get the total government expenditure on TCAM. The total government expenditure on TCAM (HC.RI.2) is further divided into HC.RI.2.1 of which inpatient and HC.RI.2.2 of which outpatient, applying the same allocation formula used for separating inpatient and outpatient in hospitals and dispensaries (as mentioned earlier in this section). This also includes administrative expenditure, which should be allocated into inpatient and outpatient in the same proportion.

4.2.1.5 Factors of provision

The factors of provision as per given classification (Table 5) can be obtained from the detail demand for grants of Union as well as State Government's Department of Health and Family Welfare and the other departments (other than health and family welfare) expenditure on health and health related activities. Every detail demand for grant is arranged as per the 6 tire coding system and the 6th tire is the object head. These detail heads appear under each and very sub minor head to provide the details of expenditures under the specific sub minor head. The classification of all object heads as different factors of provision is given in **Table 4.15.**

Table 4.15: Cross walk of detail heads in demand for grants into FP classifications

Description	FP
Grants-in-aid Salaries	FP.1.1
Grants-in-Aid-General (Salary)	FP.1.1
Overtime Allowance	FP.1.1

Description	FP
Salaries	FP.1.1
Wages	FP.1.1
Medical Reimbursement	FP.1.2
Scholarships and Stipends	FP.1.2
Scholarships Stipends & Concessions	FP.1.2
Domestic Travel Expenses	FP.1.3
Foreign Travel Expenses	FP.1.3
Travel Expenses	FP.1.3
Honorarium	FP.2
Professional & Special Service	FP.2
Professional Services	FP.2
Machinery and Equipment	FP.3.1
Medical Treatment	FP.3.1
Material and supply	FP.3.2
Supplies and Materials	FP.3.2
Advertising and Publicity	FP.3.3
Grants-in-Aid-General (Non-Salary)	FP.3.3
Hospitality &Ent. Expenses	FP.3.3
Maintenance	FP.3.3
Motor Vehicles	FP.3.3
Motor Vehicles (Outsourced Vehicles/Pol/Repairs)	FP.3.3
Office Expenses	FP.3.3
Other Administrative Expenses	FP.3.3
Other Contractual Services	FP.3.3
POL	FP.3.3
Publications	FP.3.3
Training	FP.3.3
Transfer Expenses	FP.3.3
Liveries	FP.3.4
Grants for Creation of Capital Assets	FP.4
Grants-in-Aid For Capital Assets	FP.4
Major Works	FP.4
Other Charges	FP.5.1
Other charges (Charged)	FP.5.1
Rent Rates and Taxes	FP.5.1
Contributions	FP.5.2
Minor Works	FP.5.2
Subsidies	FP.5.2

4.2.2 Health expenditure by other state departments (non- employees)

There are other state departments that spend on health through various programs. The significant ones given in **Table 4.16** are just indicative due to changing health system context. NHA team should always improve upon this list within preview of boundary of healthcare for India. Each of these programs and relevant healthcare expenditure are explained below. However certain programs categorised as Health Insurance will be dealt in detail in the respective chapter.

Table 4.16: Other state departments incurring expenditures on health (states examples)

State	Department	Description of Sub-Minor Head
Rajasthan	Public works	Director, health and family welfare
		Director, Ayurveda
		Director, Mobile medical unit
	Information & publicity	Free medical treatment to reporters
	Welfare of SC, ST & OBC	Sub-centre under Devnarayan scheme
		Mobile hospitals- under Devnarayan scheme
	Social Security & Welfare	Welfare of handicapped
		For medical aid to the state pensioners
		Director- state insurance department - Mediclaim for new recruitment
	Secretariat social services	Medicine and public health and Ayurveda
	Ecology &Environment	Bio-medical waste management
	Police	Special force/medical branch
Jharkhand	Welfare of scheduled castes, scheduled tribes and other backward classes	1. Ayurvedic and thakkar leprosy prevention centre
		2. State scheme education-renovation - re-organization of ayurvedic medical centres
		3. State scheme for other welfare programmes-medical aid
		4. Special health scheme for Paharia
		5. State scheme for other welfare programme - supply of medicine to ayurvedic centre
		6. State scheme for maintenance of rural hospital.
	Public works	Maintenance of rural health centers/ sub-center buildings
	Crop husbandry	Grants-in Aid to state medicinal mission
	Home department/state police	Arrangement of ambulance-
		State scheme construction/strengthening of jail hospitals/extension and up-gradation of medical facilities
	Industries	Health insurance schemes for weavers
	Women and child development	State scheme – special equipment for disabled
Punjab	"President, vice president / governor, administrator of union territories"	Medical facilities
	Police	Police hospitals
	Labour	Working condition and safety
	Relief on account of natural calamities	Public health
	Compensation and assignments to local bodies and panchayati raj institutions	Grants for service provider doctors in rural dispensaries (rural medical officers)
Jammu and Kashmir	Labour and employment	Employment insurance
	Social security and welfare	Group Mediclaim insurance
Bihar	Social security and welfare	1. Rashtriya Swasthya Bima Yojana (RSBY)
		2. Indira Gandhi Matritva Suraksha Yojana
	Public works	Rural health facilities (repair and maintenance)
	Pension and other retirement benefits	1. Medical facilities to retired judges and their families
		2. Medical facilities to retired high court judges and their families
		3. Medical facilities to ex-MLAs.
	Housing	Rural health facilities (repair and maintenance)
	Welfare of scheduled castes, scheduled tribes and other backward classes	Leprosy treatment cell
	Labour and employment	Education, health and recreation
	Social security and welfare	CM medicine relief fund
	Relief on account of natural calamities	1. Natural calamities: public health (medicines).
		2. Natural calamities: public health (repair and re – establishment of health infrastructure)

State	Department	Description of Sub-Minor Head
Haryana	President/vice president / governor / administrator of union territories	"Medical facilities to the governor and his family & staff."
	Public works	Prorata provision for Public Health department establishment
	Labour and employment	1. Health
		2. Working conditions and safety
	Relief on account of natural calamities	Public Health
	Social security and welfare	1. Insurance scheme (Niramaya)
		2. RSBY
	Agriculture	National mission on medicinal plants
	Rural and Community Development	Rural health & sanitation programme
	Industries	Health insurance scheme
Himachal Pradesh	Governor and council of ministers	Medical facilities to Governor, his family and staff
	Land revenue and district administration	1. Expenditure on supply of medicine
		2. Public Health
		3. Expenditure on Public health
	Planning and backward area sub-plan	1. Medical and Public Health
		2. Capital outlay on medical and public health
Sikkim	Forest, environment and wildlife management	National mission on AYUSH including mission on medicinal plants
	Public works	Maintenance & repairs of hospitals & health centres, etc.
	Horticulture and cash crops development	National mission on medicinal plants
Odisha	Revenue and disaster management department	Public health
	Odisha legislative assembly	1. Health insurance scheme
		2. Health insurance scheme for ex-MLAs
	SC /ST development, minorities and backward class welfare department	Health measures
	Labour and employment	Working conditions and safety
Kerala	Social security and welfare	1. State initiative in the area of Disability –prevention, detection, early intervention, education, employment and Rehabilitation.
		2. Assistance to Regional Institute for Physical Medicine and Rehabilitation (RIPMER), Thrissur.
		3. Programmes for rehabilitation of
		Children with autism spectrum disorders
Delhi	Education	Menstrual hygiene in girls
	Social welfare	Rehabilitation services
		Assistance for prevention of alcoholism and substance abuse and for social defence service
	Women and child development	Mental health unit
	Welfare of SC/ST & backward classes	Matri Shishu Suraksha Yojana
		GIA for antenatal care and institution delivery for SC women
	Development	Relief on account of natural calamities
	Urban development public works	Capital outlay on medical and public health
Goa	Labour and employment	Working conditions and safety
	Women and child development	Integrated child development scheme including health cover

State	Department	Description of Sub-Minor Head
Karnataka	Labour and employment	RSBY (Rashtriya Swastha Bima Yojana)
	Social security and welfare	Hand book on information education and communication (IEC) - health and nutrition
	Women and child development	Meeting medical expenses of malnourished children
	Forestry and wildlife	Conservation and development of medicinal plants – Herbal Medicine Authority
		Maintenance of medicinal plant conservation areas (MPCAS) and medicinal plant development areas (MPDAS)
Andhra Pradesh	Governor and council of ministers	Medical facilities
	Revenue, registration and relief	Relief on account of natural calamities
	Labour and employment	Employees State Insurance Scheme
Telangana	Governor and council of ministers	Medical facilities
	Revenue, registration and relief	Relief on account of natural calamities
	Labour and employment	Employees State Insurance Scheme

The typical codes to look for to find the categories for other departments budgets which may contribute to health are given as an example from Rajasthan in the **Table 4.17** and the classification codes are given in **Table 4.18.**

Table 4.17: List of all the major heads under which Government health expenditure are booked in the state of Rajasthan

Major Head	Description of Major Heads	Major Head	Description of Major Heads
2210	Medical and Public Health	2245	Relief on account of Natural Calamities
2211	Family Welfare	2250	Other Social Services
2011	Parliament/ State/ Union Territory Legislators	2251	Secretariat Social Services
2012	President/ Vice-President/ Governor/ Administrator of Union Territories	2401	Crop Husbandry
2013	Council of Ministers	2402	Soil and Water Conservation
2014	Administration of Justice	2403	Animal Husbandry
2015	Elections	2405	Fisheries
2029	Land Revenue	2406	Forestry and Wild Life
2030	Stamps and Registration	2425	Co-operation
2035	Collection of other taxes on Property and Capital Transactions	2435	Other Agricultural Programmes
2039	State Excise	2515	Other Rural Development programmes
2040	Taxes on Sales, Trade etc.	2575	Other Special Area Programmes
2041	Taxes on Vehicles	2700	Major Irrigation
2045	Other taxes and duties on commodities and services	2701	Major and Medium Irrigation
2047	Other fiscal services	2702	Minor Irrigation
2051	Public Service Commission	2705	Command Area Development
2052	Secretariat-General Services	2802	Petroleum
2053	District Administration	2810	Non-Conventional Sources of Energy
2054	Treasury and Accounts Administration	2851	Village and Small Industries
2055	Police	2852	Industries
2056	Jails	2853	Nonferrous Mining and metallurgical Industries
2058	Stationery and Printing	3054	Roads and Bridges
2059	Public Works	3425	Other Scientific Research

Major Head	Description of Major Heads	Major Head	Description of Major Heads
2070	Other Administrative Services	3435	Ecology and Environment
2075	Miscellaneous General Services	3451	Secretariat-Economic Services
2202	General Education	3452	Tourism
2203	Technical Education	3454	Census Surveys and Statistics
2204	Sports and Youth Services	3456	Civil Supplies
2205	Art and Culture	3475	Other General Economic Services
2215	Water Supply and Sanitation	4217	Capital Outlay on Urban Development
2216	Housing	4700	Capital Outlay Major Irrigation
2217	Urban Development	4701	Capital outlay on Major and Medium Irrigation
2220	Information and Publicity	4702	Capital outlay on Minor Irrigation
2225	Welfare of Schedule Caste, Scheduled Tribes and other Backward Classes	4705	Capital Outlay on Command Area Development
2230	Labour and Employment	4210	Capital Outlay on Medical and Public Health
2235	Social Security and Welfare	4211	Capital Outlay on Family Welfare
2236	Nutrition		

Table 4.18: Identifying state government other departments health expenditure to SHA 2011 framework classifications and codes

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.1.1.2.1State government schemes (Non-Employee))
Revenue of the financing scheme (FS)	FS.1.1.2 Internal transfers and grants – State Government
Healthcare Providers (HP)	HP.1.1.1 General Hospitals – Government HP.1.2 Mental health hospitals – Government HP.1.3.1 Specialised hospitals – Government HP.3.3 Other healthcare practitioners – Government HP.6 Providers of preventive services HP.7.1 Government health administration agencies
Healthcare Functions (HC)	HC.1.1.1 Inpatient curative care – general HC.1.1.2 Inpatient curative care – specialized HC.1.3.1 Outpatient curative care – general HC.1.3.2 Outpatient curative care – Dental HC.1.3.3 Outpatient curative care – specialized HC.2.nec rehabilitative care HC.3.nec Long term care HC.4. 3 Patient transportation HC.6.1.nec Information, education and counselling programmes HC.6.2 Immunisation programmes HC.6.3 Early disease detection programmes HC.6.4 Healthy condition monitoring programmes HC.6.5.nec Epidemiological surveillance and risk and disease control programmes HC.6.6 Preparing for disaster and emergency response programmes HC.7.1.nec Governance and Health system administration HC.7.2 Administration of health financing HC.9 Other healthcare services not elsewhere classified (nec) HC.RI.1 Total pharmaceutical expenditure HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

4.2.2.1 Data sources

The detailed demand for grants are important source of data on state other department's expenditures on health.

4.2.2.2. Boundaries

The Demand for Grants of each State Department (including the Department of Health and Family Welfare) should be scanned line item by line item, to identify expenditures on health incurred by different state departments (for e.g. Department of Finance, Labour Welfare, Education, etc.). The identified line items should be further assessed as per the given criterion under healthcare boundaries for India.

4.2.2.3 Mapping and classification

According to SHA 2011, these schemes are classified and coded as given in **Table 4.19**. Each expenditure line item is mapped to different codes

Table 4.19: Other state departments' classification and mapping

Department	Major Head	Sub Major Head	Minor Head	Sub Minor Head	(CC) /(HK)	FS	HF	HP	HC
Public works	2059	053	08	director, health and family welfare	HK				
information and publicity	2220	800	01	free medical treatment to reporters	CC	FS.1.1.2	HF.1.1.2.1	HP.1	HC.1.1.1
welfare of SC, ST and OBC	2225	08	01	sub-centre under devnarayan scheme	CC	FS.1.1.2	HF.1.1.2.1	HP.3.3	HC.6.1
social security and welfare	2235	02	101	welfare of handicapped	CC	FS.1.1.2	HF.1.1.2.1	HP.1.3	HC.1.1.2
		60	102/02/01	for medical aid to the state pensioners	CC	FS.1.1.2	HF.1.1.2.1	HP3.1.1	HC.1.3.1
		800	02/01	director- state insurance department- med claim for new recruitment	CC	FS.1.1.2	HF.1.1.2.1.3.2	HP.7.1	HC.7.2
secretariat-social services	2251	090	02	medicine and public health and ayurveda	CC	FS.1.1.2	HF.1.1.2.1	HP.1.3	HC.1.3.1
ecology & environment	3435	06	01/06	bio-medical waste management	CC	FS.1.1.2	HF.1.1.2.1	HP.1.1	HC.1.nec
police	2055	104	02	special force/medical branch	CC	FS.1.1.2	HF.1.1.2.2	HP.1.1	HC.1.1.2

4.2.3 Health expenditure by state departments (employees)

The State Government, similar to union government spends on the health of its employees. The State Government employees get their medical bills reimbursed from the government on producing health bills as per the state guidelines and the General Financial Rules (GFR) are followed for making such reimbursements.

4.2.3.1. Data sources

The States' budget documents, detailed demand for grants of all department including department of Health & Family Welfare.

4.2.3.2. Mapping and classification

The detailed Head "06"is exclusively for medical treatment/ medical expenses and is classified by SHA 2011 codes as shown in **Table 4.20.**

Table 4.20: Other State departments' classification and mapping

Budget head	(CC) /(HK)	FS	HF	HP	HC
Medical Reimbursements (by all departments)	CC	HF.1.1.1.2	FS.1.1.1	HP.10	HC.9

4.3 Health Expenditure by Local Government

Local bodies are institutions of the local self-governance, which look after the administration of an area or small community such as villages, towns, or cities. The Local bodies in India are broadly classified into two categories. The local bodies constituted for local planning, development and administration in the rural areas are referred as Rural Local Bodies (Panchayats) and the local bodies, which are constituted for local planning, development and administration in the urban areas, are referred as Urban Local Bodies (Municipalities)

Local Government is a State subject figuring as item 5 in List II of the Seventh Schedule to the Constitution of India. Article 243 G of the Indian Constitution enshrines the basic principle for devolution of power to the Local Bodies.

The many roles that the local government is expected to play today include:

- Regulator, namely the administration of various acts and regulations
- Provider, that involves providing services efficiently and equitably by managing its accounts effectively and efficiently, more so in urban areas.
- Agent that takes the schemes of higher levels government to the people. This includes promotion of popular participation
- Welfare agency, which provides active assistance to higher level governments in the equitable distribution and delivery
- Agent of Development, who strives for improvement in the quality of life through the augmentation of infrastructure

4.3.1 Health expenditure by rural local bodies

The revenues of rural local bodies (RLBs) comprise of three parts, namely, own revenues (tax and non-tax revenues), transfers from state governments, and transfers from the central government. RLBs have been assigned various revenue raising powers through legal provisions, which are used to garner own revenues. Such provisions typically empower them to fix, collect and retain taxes and user charges. Additionally, selected taxes collected by the State government are often assigned either wholly or partly to RLBs. For these assigned taxes, the amount of revenue generated and shared by State governments depends upon the States' tax effort. Transfers from State and Central governments are typically classified as revenue transfers and not capital transfers.

Rural local bodies depend largely on transfers from higher levels of government for creation of assets, their maintenance and effective service provision. However, a predominant part of these transfers in India are tied to specific purposes. This makes local governments function more as implementing agencies of service delivery, rather than institutions of local self-governments with adequate power and responsibilities for implementation, and accountability for any failure to do so.

RLBs have little revenues of their own. Own revenues are significant at village level and marginal at district and block level. In addition to own revenues, RLBs get assigned revenues and untied grants from the Central and State Governments. The RLBs have the autonomy to decide what to spend on from these untied resources.

The revenues of the Panchayats comprises of three parts, namely, own revenues (which in turn comprises of tax revenues and non-tax revenues), Transfers from the state government, and transfers from the central government. With respect to the first category of revenues, RLBs have been assigned various revenue raising powers through legal provisions. Such provisions typically empower them to fix, collect and retain for their use various taxes and user charges. Apart from this avenue, many taxes collected by the State government may be assigned to be shared, either wholly or partly, with RLBs. In such circumstances, the amount of money collected and shared depends upon the tax effort expended by the State governments. On the question of transfers from the State and Central governments, these fund transfers are typically classified as revenue transfers and not capital transfers.

The Panchayats have more autonomy in spending the revenues collected by themselves (own revenues), assigned by states in the form of shared tax revenues also known as statutory transfers and transfers from the centre under the recommendations of the Central Finance Commission. Even in the case of assigned transfers from the states and central finance commission, though are untied, many times some stings are attached in the sense that major portion of the same can be spent only on asset creation and asset maintenance. The following section gives a bird eye view of the revenues of rural local bodies based on the sample in 17 states.

4.3.1.1. Data source

Fourteenth Finance Commission data on rural local bodies collected by the Finance Commission of India was procured.

Note: The data collected by Fourteenth Finance Commission does not provide disaggregated information on what activities the money was spent. Therefore, it is not possible to classify the healthcare ex-penditure by RLBs according to the SHA 2011 framework. However the absolute value of total health-care expenditure by RLBs will be included in final estimates so that we do not miss these expenditures.

At state level, NHA teams are advised to collect detailed data from rural local bodies along with the functions they perform and classify them according to the SHA 2011.

4.3.1.2. Mapping and classification

The expenditures by rural local bodies from their own revenues are classified as follows:

HF.1.1.2.1.1 State Government Scheme (Non-Employee)

FS.1.1.3.2 Rural Local Bodies

HP.6 Providers of Preventive care

HC.6.4 Healthy Condition Monitoring Program

4.3.2 Health expenditure by urban local bodies

Urban Local Bodies (ULBs) directly influence the welfare of the people in urban areas by providing civic, social and economic infrastructure services and facilities. Following the 74th amendment of the constitution more functions, powers and resources have been provided to ULBs. ULBs act as a financing source, agent and provider of healthcare in urban areas.

Given the huge number of ULBs which serves around one third of the country's population it is pertinent to understand the fund flow that takes place at the urban centers for provision of health. ULBs expenditure on health is part of overall public expenditure on health that takes place in the country. The health expenditure of ULBs includes transfers of funds meant for health spending from state and central government and also from resources mobilised within the ULBs.

ULBs in India are divided into three types of organisations, Nagar Panchayats, Municipal council and Municipal corporations. (i) a Nagar Panchayat for transitional areas i.e. an area in transition from rural to urban, (ii) a Municipal Council for a smaller Urban area and (iii) a Municipal Corporation for a larger urban area. Most states have amended their municipal laws in conformity with the 74th constitutional amendment. However,

variations are found in the definition of small and large urban areas, as well as in transitional areas. As per the estimates given by the 14th finance commission, there are 162 municipal corporations in the country, 1482 municipalities and 2349 nagarpanchayats.

Revenues of ULBs

Own Revenue Source: Own revenue sources for ULBs include tax and non-tax resources. The former includes property tax, advertisement tax, vacant land tax, etc., and the latter includes user charges, market fees, betterment charges, etc.

Assigned revenue: It refers to all forms of revenue transfers to local bodies from specific sources of State government revenue. Assigned revenues of municipal bodies include: profession tax, entertainment tax, surcharge on stamp duty, compensation for loss of income on tolls, motor vehicle tax and octroi.

Grants in aid: It includes Plan and Non Plan grants from Central and State governments. Grants may be ad hoc or based on size of population, a specific purpose or as an incentive for performance.

Loan/Borrowing: Loans basically includes Borrowings for capital works from state and central governments, financial institutions, municipal bonds, etc.

Out of the 18 core functions of the ULBs, Public health including prevention of communicable diseases is one of the core functions of local governments. Apart from core function, local bodies also have discretionary or permissive functions which the local governments may undertake at their convenience depending on devolution of such functions by the State government along with funds and functionaries to perform them.

4.3.2.1. Data sources

There are multiple sources to collect information on ULBs. At the state level following sources can be used.

1. Websites of different ULBs.
2. Statistical Abstract of States.
3. India Statistical Abstract.
4. Office of the Municipal Administration at the State level.
5. Department of Economics and Statistics at the State level.
6. Annual Reports of the Municipal Corporations.
7. Urban Development Plans

Budgets of ULBs vary across the states and it requires taking a careful look at the allocation on health. Generally health expenditure falls under the head of public health but it is very much possible certain elements (eg: water and sanitation) might be included in the same head which falls outside the purview of health expenditure.

Due to lack of required information on health expenditure by ULBs a survey can be designed. This survey collects information on health facilities operating under the ULBs with focus on manpower, infrastructure and utilization of health facilities along with the information on revenue and expenditure of the ULBs on health.

Nature of information to be collected from Municipal Corporation and Councils are given as follows:

1. Establishment Expenses
2. Administrative Expenses
3. Maintenance and Operation
4. Interest and Other Charges
5. Programme Expenses
6. Expenses under Revenue Grant, Contribution and Subsidies.
7. Other Expenses

Structured format (shown in A1 at the end of the guidelines) is used to collect in formation from the ULBs. Information on both revenue and expenditure of the ULB along with expenditure on heal this collected for the last three years. Information under health expenditure is collected at the disaggregated level according to different health functions. This survey also collects information on health facilities operating under the ULBs with focus on manpower, infrastructure and utilisation of health services for both inpatient and outpatient.

4.3.2.2 Boundaries

Expenditure by ULBs also includes sanitation services, cremation, animal care etc. which lies outside the SHA boundary and should be removed.

4.3.2.3 Mapping and classification of health expenditures by ULBs

According to the SHA 2011 framework, health expenditures by ULBs in India are identified to their respective classification and codes as given below in **Table 4.21**

Table 4.21: Identifying ULBs health expenditure to SHA 2011 framework and classifications

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.1.1.2.2.1 Urban local bodies
Revenue of the financing scheme (FS)	FS.1.1.1 Internal transfers and grants – Union Government
Institutional unit and financing agent	FS.1.1.2 Internal transfers and grants – State Government
	FS.1.1.3.1 Urban local bodies
Healthcare Providers (HP)	HP.1.1.1 General hospitals – Government
	HP.3.4.9 All other ambulatory Clinics – Government
	HP.6 Providers of preventive services
	HP.7.1 Government health administration agencies
Healthcare Functions (HC)	HC.1.1.1 Inpatient curative care – general
	HC.1.1.2 Inpatient curative care – specialized
	HC.1.3.1 Outpatient curative care – general
	HC.1.3.2 Outpatient curative care – Dental
	HC.1.3.3 Outpatient curative care – specialized
	HC.2.nec rehabilitative care
	HC.3.nec Long term care
	HC.4. 3 Patient transportation
	HC.6.1.nec Information, education and counselling programmes
	HC.6.2 Immunisation programmes
	HC.6.3 Early disease detection programmes
	HC.6.4 Healthy condition monitoring programmes
	HC.6.5.nec Epidemiological surveillance and risk and disease control programmes
	HC.6.6 Preparing for disaster and emergency response programmes
	HC.7.1.nec Governance and Health system administration
	HC.7.2 Administration of health financing
	HC.9 Other healthcare services not elsewhere classified (nec)
	HC.RI.1 Inpatient pharmaceutical consumption
	HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

The mapping for each expenditure line item is presented in **Table 4.22.** Description of expenditure line item is in Column 1. All expenditure line item related to current consumption (CC) or captial expenditure/capital account (HK) are marked as CC or HK in Column 2; expenditure value is in Column 3; SHA 2011classification codes for Revenue of financing schemes (FS), Health financing schemes (HF), Healthcare Providers (HP) and Healthcare functions (HC) are in Column 4 - 7.

Table 4.22: Local bodies' budget classification and mapping

Expenditure line items under block grants	CC/HK	Expenditure	Revenues of Financing Schemes (FS)	Financing Schemes (HF)	Healthcare Providers (HP)	Healthcare Function (HC)
Primary Health Centres	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.3.4.9	HC.1.3.1
Taluk level General Hospitals	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1	HC.1.1.1, HC.1.3.1
Opening and Maintenance of AYUSH hospitals and dispensaries	HK					
Local fund Combined hospitals and dispensaries	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1 / HP.3.4.9	HC.1.1.1, HC.1.3.1
District Hospitals of AYUSH and GIA to Private Hospitals	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1 / HP.3.4.9	HC.1.1.1, HC.1.3.1
Maintenance of Health Buildings	HK					
Drugs & Chemicals of AYUSH Department	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.3.1	HC.1.1.1, HC.1.3.1
Opening & Maintenance of Unani Dispensaries	HK					
National Anti - Malaria Programme	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.6	HC.6.5.nec
Primary Health Centres (GOI Pattern) (MNP)	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.3.4.9	HC.1.3.1
Karnataka Health System Development Project	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.3.4.9	HC.1.3.1
Dental Units to Taluk Hospitals	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1	HC.1.3.2
Buildings	HK					
District Health Office Buildings	HK					
State Health Transport Organisation	HK					
Population Centres	HK					
Continuation of Health Centres under CHCs created under IPP-VIII	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.3.4.1	HC.6.4
District Establishment	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.7.1	HC.7.1.nec
Repairs to Hospital Equipment	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1	HC.1.1.1
X-Ray Facilities to Taluk Hospitals	HK					
Supply of Drugs and Syringes and Pulse Polio Immunisation	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.6	HC.6.2
Provision for Ambulances	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.4.1	HC.4.3
Mobile Health Units	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1	HC.1.3.1
Transportation of Vaccine for Regional District Stores	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.6	HC.6.2
Establishment of Blood Bank	CC		FS.1.1.2	HF.1.1.2.2.1,	HP.1.1.1	HC.1.1.1

A grant to the Zilla Parishads from the department of Health and family welfare is in form of consolidated funds. The detailed allocation of these funds can be obtained from the department of finance of the state. Other allocations can be directly obtained from the survey data.

4.3.3 Developing allocation keys for some line items (Section common for RLBs and ULBs)

HC.RI.1 Total Pharmaceutical Expenditure

The data on health expenditure by Rural Local Bodies generally does not have detailed information on expenditures on drugs and consumables. To obtain these expenditures it is advisable to use the same

proportions in which the respective state health department has spent for procuring drugs and consumables (refer to section sub section HC.RI.1 Total Pharmaceutical Expenditure in section 4.2.1 – Development of allocation keys for some line items; of this chapter). Once you obtain total pharmaceutical expenditure, the total is further divided into "HC.RI.1.1 of which inpatient" and "HC.RI.1.2 of which outpatient", applying the same allocation formula used for separating inpatient and outpatient in hospitals and dispensaries (refer to section sub section Hospitals and Dispensaries in section 4.2.1 – Development of allocation keys for some line items; of this chapter).

The format for budget documents of Urban Local Bodies varies from state to state, but is same for all the ULBs in the same state. Hence, it is advisable that the study team collects all the data on health expenditure by ULBs from all the ULBs with-in their state. All major ULBs have one or more line items for drugs and consumables; Two examples are presented below: 1. In the Municipal Corporation of Bangaluru [BBMP] budget all health expenditures are recorded under the head "13 – Health General". Under this head there are several other heads that describe different expenditures on health. Under the section "Public Health" that reflects under the head "Health and Sanitation" there are expenditure line items that report expenditure on drugs and medicines. The addition of all these detail heads will provide the total expenditure on pharmaceuticals by ULBs in Karnataka. The detail heads are as follows (a) P0093 – Purchase of Drugs and Medicines (Hospitals), (b) P0506 – Purchase of Anti Rabies Vaccine, (c) P0510 – Purchase of medicines and other accessories and Tele-medicine facility in BBMP Hospitals, (d) P0511 – Purchase of medicines (Hepatitis B) and (e) P0512 – Purchase of maternity equipment, medicines and linen.

2. The budget document of Vasai-Virar City Municipal Corporation in Maharashtra has only one line item "18 – Purchase of medicines and drugs (Hospitals)", under the main head "Management of Hospitals and Dispensaries at different places within the city". This head is common for all municipal corporations in Maharashtra. The expenditure under this head should be collected from all ULBs within the state. Finally all these line items should be added together to get the total expenditure on drugs and medicines by ULBs.

Once the total pharmaceutical expenditure (i.e. HC.RI.1) by ULBs within the states is obtained, this total is further divided into "HC.RI.1.1 of which inpatient" and "HC.RI.1.2 of which outpatient", applying the same allocation formula used for separating inpatient and outpatient in hospitals and dispensaries (refer to section sub section Hospitals and Dispensaries in Section 4.2.1 – Development of allocation keys for some line items; of this chapter).

HC.RI.2 Traditional Complementary and Alternative Medicine (TCAM)

The state government gives grant in aid to ULBs and RLBs, and it reflects in the detail demand for grants of "State Department of Health and Family Welfare", as grant in aid to local bodies. This line item when appears under the sub major head "02 - Urban Health Services Other Systems of Medicine" it should be considered as grant in aid to ULBs for AYUSH or TCAM and can be marked accordingly. Similarly, the line item "grant in aid to local bodies" when appears under sub major head "04 – Rural Health Services Other Systems of Medicine" it should be considered as grant in aid to RLBs for AYUSH or TCAM.

In addition to this the local bodies also generate their own revenues and spend it on different activities. The data on expenditure on TCAM by RLBs from their own resources is not available, one might consider contacting the local authorities for such data as different states have a different system of reporting expenditures by RLBs from their own resources.

The data on expenditure on TCAM by ULBs from their own revenues is available in their budget books. The study team can carefully scan through the entire budget document and identify line items such as "District Hospitals of AYUSH", "Drugs and Chemicals of AYUSH department", etc. The expenditure under all these line items should be added together to obtain the total expenditure on TCAM by ULBs in that state. After the total expenditure on TCMA (i.e. HC.RI.2) is obtained, it is further divided into HC.RI.2.1 of which inpatient and HC.RI.2.2 of which outpatient, applying the same allocation formula used for separating inpatient and outpatient in hospitals and dispensaries (refer to section sub section Hospitals and Dispensaries in section 4.2.1 – Development of allocation keys for some line items; of this chapter. This also includes administrative expenditure which should be allocated into inpatient and outpatient in the same proportion.

CHAPTER 5

Private Health Expenditures

5.1 Household Health Expenditures

Household health expenditures are either direct expenditures (out of pocket payments) or indirect expenditures (prepayments as health insurance contributions or premiums). For estimating household health expenditures, categories of revenues of financing scheme are aggregated - FS.3.1 Social insurance contributions from employees, FS.5.1 voluntary prepayments from individuals/ households, and FS.6.1 Other revenues from households.nec

This section focuses on guidelines to estimate household out of pocket expenditures (FS.6.1 Other revenues from households n.e.c) in India at national level. The guidelines to estimate other revenues of financing schemes of the households i.e FS.3.1 Social insurance contributions from employees, FS.5.1 voluntary prepayments from individuals/ households, are discussed in-depth in the chapter 6 of this guideline.

Out-of-pocket (OOP) payments are defined as the payments made by an individual/household at the point of service directly where the cost of the health good or service is either not covered under any social protection or insurance scheme or is partially covered. India has a very large proportion of household health expenditures[51]. This includes expenditure on inpatient care, outpatient care, family planning, immunization, drugs, diagnostics, medical non-durables, therapeutic appliances from various healthcare institutions.

In this chapter section 5.1.1 presents the data sources for household OOP expenditures; section 5.1.2 is on boundaries for household OOP expenditures, section 5.1.3 describes the household OOP expenditures within the SHA 2011 framework and classifications; section 5.1.4 provides the methodology for estimation of OOP and section 5.1.5 presents methodology to derive estimates for expenditure line items from data sources

5.1.1 Data sources for estimating household out of pocket expenditures for NHA

Two primary sources of data exist for estimating household out of pocket expenditures. These are National Health and Morbidity survey (HS) and Consumer expenditure survey (CES) conducted by the National Sample Survey Office (NSSO). Intercontinental marketing services (IMS) health and National Family Health Survey is used to derive estimates for other health expenditures such as immunization, vitamins and minerals, family planning services etc. If the states have their own data sets for expenditures on immunisation, vitamins and minerals, and family planning services, those can be used to arrive at estimated expenditures for these items for NHA.

51 According to National Health Accounts (NHA) 2004-05, households financed 71% of total health expenditure in India, mainly through out of pocket expenditures

5.1.1.1 National health and morbidity survey (HS)

This survey is conducted once in every 10 years. The latest survey is available for 2014-15 and reported as NSSO 71st round: Social Consumption: Health, January to June 2014 (NSS-HS 71). This forms the main source of data to estimate OOP expenditures on health. The reason for choosing health survey over CES is the detailed information for health services, its sample design and the robustness, and the disaggregated information that is available in NSS-HS 71.

This survey provides information on both inpatient and outpatient categories of healthcare expenditure. For each category of expenditure, it provides information on nature of ailment, duration of ailment number of episodes of ailment for each family member for whom this expenditure was undertaken. Disaggregation of expenditure by the type of healthcare facility; public or private, health sub center, hospital or clinic; is also available. For inpatient expenditure, information is provided for each episode of hospitalization for every such individual, who underwent hospitalization. For outpatient expenditure, information is available per person, for each individual who sought healthcare, as an aggregate for all episodes of treatment or as an aggregate for all treated ailments as the case maybe. Reference period is last 365 days for inpatient care and last 15 days (from the date of survey) for outpatient care. It provides the information on the amount of reimbursement by the employer or the insurance company and the amount of insurance premium paid by households. Separate information is also available for expenditure on antenatal and post-natal care; traditional and alternative systems of medicines along with other medical expenditure that includes attendant's charges, physiotherapy, medical appliances etc which cannot be separated out from NSS-HS 71. Separate information is not available on expenditure on various therapeutic appliances like hearing aids, contact lenses, orthopedic equipment's etc.

5.1.1.2 Consumer Expenditure Survey (CES)

This survey is conducted by NSSO once in every five years for a large sample size and once every year for thin sample. The latest survey available for large sample size is the CES 68th round for 2011-12. There is a difference in the sampling design of CES and HS. CES is aimed at generating estimates of levels of standard of living and pattern of household monthly per capita consumer expenditure (MPCE) on different commodity groups. CES contains information on consumption expenditure undertaken by households on 350 food and nonfood items, including information on expenditure on institutional (inpatient) and non-institutional (outpatient) medical care. CES, under the categories of both inpatient and outpatient healthcare expenditure, provides the information on expenditures on medicines, doctors' fee, diagnostic expenditures, hospital/ nursing home charges (for institutional care), and family planning devices (for non-institutional care). Healthcare expenditure includes ambulance charges for transporting patients and expenditure on medical termination of pregnancy. It also includes those categories of expenditure, which may have been reimbursed, by the employer or insurance company but the information on how much amount was reimbursed or how much insurance premium was paid is not available. Information is also available on expenditure on various therapeutic appliances like hearing aids, contact lenses, and orthopedic equipment with a reference period of one year. Reference period for expenditure on non-institutional medical care is 30 days. Information for expenditure on institutional medical care is available for a reference period of 365 days. CES does not provide disaggregated information such as the type of healthcare facility, whether public or private, type of ailment that the respondents were suffering from, etc.

CES was used for estimating expenditures on therapeutic appliances which were not available separately as a part of NSS-HS 71. Family planning expenditures were also estimated from CES to triangulate with recent data obtained from NFHS survey described below.

5.1.1.3 The National Family Health Survey (NFHS)

Data from National Family Health Survey (2014-15)[52] can be triangulated with family planning data in CES surveys to get the expenditures for family planning. NFHS is a large-scale, multi-round survey conducted throughout India. The survey collects extensive information on health-related issues, including

52 http://rchiips.org/nfhs/nfhs4.shtml

fertility, infant and child mortality, maternal and child health, prenatal mortality, adolescent reproductive health, high-risk sexual behavior, safe injections, tuberculosis, and malaria, non-communicable diseases, domestic violence, HIV knowledge, and attitudes toward people living with HIV. Three Schedules were used -Household schedule, Woman and Man schedule and information was collected from all women age 15-49 and, in a subsample of households, men age 15-54. The fourth round of the survey is for the year 2015-2016. For estimating family planning expenditures, the cost of sterilization is taken which includes consultation, compensation for sterilization, facility where the sterilization took place. Data from this survey is still awaited. The estimates of the expenditure on family planning methods were based on the data available from CES 68th round for NHA 2013-14.

5.1.1.4 Intercontinental Marketing Services (IMS) health

Expenditure on vaccination was triangulated from Intercontinental Marketing Services (IMS) Health. Also expenditure on sales of vitamin and minerals can be obtained from the sales data of IMS. IMS is a global information and technology company that provides healthcare industry with the solutions to measure and improve their performance. It has a large database as their customers include pharmaceutical, consumer health and medical device manufacturers and distributors, providers, payers, government agencies, policymakers, researchers and the financial community. Expenditure on sale of vaccines and vitamins and minerals was estimated using Pharma Track data base from IMS health.

5.1.1.5 Population and consumer price index data

Population data was obtained from Census and the Registrar General of India. The Indian Census is a single largest reliable data source which provides a variety of statistical information on demographics of India and is conducted after every 10 years. To arrive at population based estimates, population of the mid-point of the six-month period (January 2014-June 2014) from Office of the Registrar General and Census Commissioner, India was used. Therefore, all estimates are first derived for population as on 1 April 2014 and then extrapolated backwards by 6 months by using Consumer Price Index to get the OOPS estimates for 2013-14.

The indicators for OOP expenditures, their data sources and the expenditure line items from the survey used to derive the expenditures are given in **Table 5.1.1.**

Table 5.1.1: Indicators, data sources, and expenditure line items for estimating out of pocket expenditures

Indicators	Data Source	Expenditure Line Item
Inpatient care	NSS-HS 71, Schedule-25, Block-7	Nature of ailment (item 6.4), level of care (item 6.6), Package component (Item 7.5), Non Package component {Doctor's / surgeon's fee (item 7.6), medicines (Item 7.7), diagnostics (item 7.8), Bed Charges (7.9), Other medical expenses (7.10), total amount reimbursed by medical insurance company or employer (Item 7.15)
Outpatient care	NSS-HS 71, Schedule-25, Block 8 & Block 9	Nature of ailment (item 8.7), level of care (item 8.14), Whether treatment taken on medical advice (Item 8.13), whom consulted (item 8.17), doctors' fee (Item 9.9), and medicines: AYUSH (Item 9.10), medicines: other than AYUSH (Item 9.11), diagnostic tests (Item 9.12), other medical expenses (attendant charges, physiotherapy, personal medical appliances, blood, oxygen etc.) (Item 9.14), total amount reimbursed by medical insurance company or employer (Item 9.18).
Over the counter medicines	NSS-HS 71, Schedule-25, Block 8 & Block 9	Whether treatment taken on medical advice (Item 8.13), whom consulted (item 8.17), medicines: AYUSH (Item 9.10), medicines: other than AYUSH (Item 9.11)
Laboratory and Imaging services (Diagnostics)[53]	NSS-HS 71, Schedule-25, Block 8 & Block 9	Whether treatment taken on medical advice (Item 8.13), whom consulted (item 8.17), diagnostic tests (Item 9.12)

53 These are excluding expenditures on diagnostics that are a part of inpatient or outpatient care.

Indicators	Data Source	Expenditure Line Item
Patient's transportation	NSS-HS 71, Schedule-25 Block 7 & Block 9	Transport for patient (Item 7.12) & (Item 9.15),
Prenatal Care	NSS-HS 71, Schedule-25 Block 11	Total expenditure incurred on prenatal care (Item 11.9)
Postnatal Care	NSS-HS 71, Schedule-25 Block 11	Total expenditure incurred on postnatal care (Item 11.14)
Family Planning devices	National Family Health Survey-4: Man's Questionnaire, Section 3	Total expenditure on sterilization including any consultation (Item 307), Whether received compensation for the sterilization? (Item 308), Compensation (Item 309), expenditure on condoms and the cost of the method and any consultation (Item 527)
	National Family Health Survey-4: Woman's Questionnaire, Section 3B	Total expenditure on sterilization including any consultation (Item 335), Whether received compensation for the sterilization (Item 336), Compensation (Item 337)
	Consumer Expenditure Survey 68th Round: Schedule 1.0, Schedule type 1	Family planning devices (Item 10.423)
Therapeutic appliances and Other medical goods	Consumer Expenditure Survey 68th Round: Schedule 1.0, Schedule type 1	Medical – non-institutional: sub-total item 10.429(420-424), medical – institutional item 10.419: therapeutic appliances: sub-total (610-611) (Item 11.619)
Immunization	Intercontinental Marketing Services	
Vitamins and Minerals	Intercontinental Marketing Services	

5.1.2 Boundaries for out of pocket expenditures

With reference to the definition of healthcare expenditures for India in chapter 2, boundaries for household health expenditures have been identified. These have been arrived using the detailed list of expenditures incurred by households as given in the National Sample Survey 71st round: Social consumption on health (NSS-HS 71). These include

- Out of pocket (OOP) expenditures on inpatient and outpatient healthcare, OOP on medicines, doctors' fee, diagnostics, bed charges, surgeries, patient's transportation and ambulance and other therapies are included as health expenditures.
- Medicines/Ancillary services that are purchased/ availed independently without prescription from health professional in the case of self-prescriptions/self-diagnosis such as over the counter medicines, are also included as health expenditures. System of Health Accounts, SHA 1.0 considered all medical goods as intermediate products[54].
- Loss of household income has been considered outside the boundary of health.
- Other miscellaneous expenditures incurred by the relatives or friends of the patient like transport cost, food expenditures, lodging charges, of wage/labor etc. are not considered as household health expenditures[55] and can be reported separately in the memorandum item for policy purpose.

54 SHA1.0 defined medical goods as those dispensed, prescribed or bought by private households at their own initiative for the purpose of home care could be interpreted as intermediate products to household production of healthcare services. All these goods are, however, reported under final consumption in the SHA. These goods can cover a wide range from incontinence material to home dialysis kit. Refer to System of Health Accounts, page 44 at http://www.oecd.org/els/health-systems/1841456.pdf

55 Refer SHA 2011, p. 58.

5.1.3 Describing and mapping out of pocket expenditures[56] within SHA 2011 framework and classifications

Households either make payments directly to public and private providers (classified below) to receive services or make indirect payments (contributions or premiums) through voluntary insurance schemes. According to the SHA 2011 framework, out of pocket expenditures in India are identified to their respective classification and codes as given below in **Table 5.1.2**. Household's out of pocket health expenditures are classified under the health financing scheme – HF.3.3 All Household out-of-pocket payments[57]. The revenue of financing scheme is household revenues classified as FS.6.1 Other revenues from households nec

Table 5.1.2: Identifying out of pocket expenditure to SHA 2011 framework and classifications

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.3 Household out-of-pocket payment HF.3.3 All Household out-of-pocket payment
Revenue of the financing scheme (FS)	FS.6 Other domestic revenues n.e.c FS.6.1 Other revenues from households nec
Healthcare Providers (HP)	HP.1.1 General Hospitals HP.1.1.1 General hospitals – Government HP.1.1.2 General hospitals –Private HP.3.1 Medical practices HP.3.1.1 Office of general medical practitioners (Private) HP.3.3 Other healthcare practitioners (Government) HP.3.4 Ambulatory healthcare centres HP.3.4.1 Family Planning Centres (Government) HP.3.4.9 All Other ambulatory centres (Government) HP.4 Providers of ancillary services HP.4.1 Providers of patient transportation and emergency rescue HP.4.2 Medical and diagnostic laboratories HP.5 Retailers and Other providers of medical goods HP.5.1 Pharmacies HP.5.2-Retail sellers and Other suppliers of durable medical goods and medical appliances HP.6 Providers of preventive care HP.10 Other healthcare providers not elsewhere classified (nec)
Healthcare Functions (HC)	HC.1.1 Inpatient curative care HC.1.1.1 General Inpatient Curative Care HC.1.1.2 Specialized Inpatient Curative Care HC.1.3 Outpatient curative care HC.1.3.1 General outpatient curative care HC.1.3.2 Dental outpatient curative care HC.1.3.3 Specialized outpatient curative care HC.1.3.nec Unspecified outpatient curative care (nec) HC.4 Ancillary Services (non-specified by function) HC.4.3 Patient transportation HC.4.4 Laboratory and Imaging services HC.5.1 Pharmaceutical and other medical non-durable good HC.5.1.4 All Pharmaceuticals and Other medical non-durable goods HC.5.2 Therapeutic appliances and Other medical goods HC.5.2.4 All Therapeutic appliances and Other medical goods HC.6 Preventive care HC.6.2 Immunization programs HC.6.4 Healthy condition monitoring programmes HC.RI.1 Total Pharmaceutical expenditure HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)

56 For arriving at household health expenditure estimates, the expenditures from households(FS.6.1), corporations (FS.6.2), NPISH (FS.6.3), social insurance contributions from employees (FS.3.1) and voluntary prepayment from individuals/households(FS.5.1) are aggregated. These are dealt with in the respective chapters of the guidelines

57 These can be further classified as HF.3.1 Out of pocket excluding cost sharing and HF.3.2 Out of pocket expenditures with cost sharing with third-party payers. Here, due to data limitations, cost sharing had a very limited meaning. Cost Sharing in NSS-HS 71 could be considered as expenditure incurred by those who received positive reimbursements. Due to complexities involved in the definition of cost sharing, it was not classified further.

The classification of healthcare providers for the OOP data is based on the available information in survey NSS-HS71, which collects the information on "level of care" in the inpatient and outpatient block as Health Sub Centres (HSC)/Auxiliary Nurse Midwifery (ANM)/Accredited Social Health Activist (ASHA) /Anganwadi Worker (AWW); Private doctor/clinic, primary health centre (PHC)/dispensary/Community Health Center (CHC)/mobile medical unit (MMU); private hospital and public hospitals as organizations/actors involved in the provision of healthcare goods and services. As all of the providers are clubbed together in NSS-HS 71, allocations were done to classify providers as general hospitals and other ambulatory care. The provider classifications used are: expenditures incurred in public hospitals are classified as HP.1.1.1 General hospitals - Government; HP.1.1.2 General hospitals. Private includes expenditures incurred in private hospitals; HP.3.1.1 Office of general medical practitioners (Private) is captured directly when the services are provided by private doctor/clinic.

In NSS-HS 71, some inpatient expenditures were reported under Health Sub Centres (HSC), Auxiliary Nursing Midwife (ANM), Accredited Social Health Activist (ASHA), and Anganwadi Workers. These were added to expenditures incurred in Community Health Centre (CHC)/Primary Health Centres (PHC)/mobile medical units (MMU)/dispensaries. These expenditures were separated as child birth and non-child birth. All expenditures incurred on non child birth cases for inpatient care were classified under HP.1.1.1 General Hospital-Government. As the child birth also take place in PHC.which are classified as HP.3.4.9, the expenditures noted under childbirth in CHC/PHC/MMU and HSC/ANM/AWW were allocated either as HP.1.1.1: General Hospital-Government or HP.3.4.9: All other ambulatory centres (Government) using an allocation formula derived from some district level surveys carried out by National Health Systems Resource Centre[58]

Outpatient expenditures incurred in Health Sub Centres and others were classified as HP.3.3: Other healthcare practitioners (Government). Outpatient expenditure incurred on CHC/PHC/MMU and child birth expenditures incurred on HSC/ANM/AWW and CHC/PHC/MMU etc. are classified as HP.3.4.9 All other ambulatory centres.

The other major providers for family care, immunization, pre natal and postnatal care are shown with mapping of expenditure line items as given in Table 5.1.3 and to the SHA 2011 classifications and codes as given in Table 5.1.2. These tables also provide mapping for functional classifications which is briefly described below. The detailed allocation ratios are explained in the Table 5.1.4.

The *functional classification* of data collected in NSS-HS 71 is as per the SHA 2011 framework. The NSS-HS 71 contains data on expenditure by households for hospitalization and non-hospitalization treatment. These have been classified as expenditure on inpatient or outpatient curative care respectively. The expenditure incurred by households during the last 365 days for treatment as inpatients of medical institutions is classified under HC.1.1 inpatient curative care. Accordingly, the sum total of expenditure on items called the package component and the non-package component in NSS-HS 71 is taken as OOP on inpatient curative care. The items that are included in the non-package component are Doctor's/surgeon's fee, medicines, diagnostic tests, bed charges, excluding total amount reimbursed by medical insurance company/employer. Also, other medical expense (attendant charges, physiotherapy, personal medical appliances, blood, oxygen etc.) from the household survey included as part of inpatient curative care.

Classifying data on expenditure (for both inpatient and outpatient curative care) into generalized and specialized care has been done on the basis of the nature of ailment provided for which the health expenditure was undertaken as shown in annexure 5.1. Classification of OOP expenditures under rehabilitative, long term care and day care has not been done in the absence of suitable data and the absence of a suitable method for apportioning the available data.

Expenses incurred by households during the last 15 days for treatment (not as in-patient of medical institution) comprise expenditure on HC.1.3 Outpatient Curative Care. OOP on outpatient is therefore a sum total of doctors' fee, medicines: AYUSH, medicines: other than AYUSH drugs, diagnostic tests when prescribed by medical

58 Surveys on household healthcare utilization and healthcare expenditure were conducted in Shimla district of Himachal Pradesh and Villupuram District of Tamil Nadu by Healthcare Financing Division, National Health Systems Resource Centre New Delhi to derive the allocation formula.

personnel[59]. It may be noted that some expenditures are reported under outpatient block for childbirth cases are included under outpatient curative care. These expenditures have been further broken down into three digit level (HC.1.3.1 General outpatient care HC.1.3.2 Dental Outpatient care: & HC.1.3.3 Specialized outpatient care) on the basis of nature of ailment. Also, other medical expenses (attendant charges, physiotherapy, personal medical appliances, blood, oxygen etc.) from the household survey for receiving outpatient care have been reported under this classification.

Expenditures on HC.4 Ancillary Services (non specified by function) includes expenditure incurred by households as outpatient during the last 15 days when expenditure on diagnostics was undertaken on consultation by self/other household members, medicines shop and others. Expenses incurred on HC.4.3: Patient transportation during the last 365 days for treatment as in-patient of medical institutions and during the last 15 days for treatment not as in-patient of medical institution, have been reported under this classification. SHA classification states that this classification includes any means of transport as long as they fit the purpose criteria and are justified by medical recommendation (SHA 2011, Pg 97). Due to unavailability of information from NSS-HS 71 and considering the importance of this indirect cost, it has been classified as HC.4.3.

HC.5.1.4 All Pharmaceuticals and Other medical non-durable goods under HC.5 Medical goods bought not specified by functions includes expenditures on medicines undertaken on consultation by self/other household members, medicines shop and others as outpatient during the last 15 days. HC.5.2.4 All Therapeutic appliances and other medical goods will have other orthopedics appliances and prosthetics (excluding glasses and hearing aids) includes expenditure on other medical equipment (from CES 68). Further, it also includes expenditures on family planning devices derived from CES 68.

Out of pocket on HC.6 Preventive care includes expenditures under HC.6.2 Immunization programmes and HC.6.4 Healthy condition monitoring programmes. The NSS-HS 71 provides limited information on immunization. It only collects information on whether women received tetanus toxoid vaccine or Iron Folic Acids (IFA) during pregnancy. Immunization data from Intercontinental Marketing Services (IMS) which provides data on retail sales of vaccines to household are used.

The expenditure on prenatal and post-natal care is included under HC.6.4 Healthy condition monitoring programmes . This category includes distribution of contraceptive methods including emergency contraception, anemia prevention and control in maternal and child conditions.

Certain reporting items important from the policy perspective are reported for the OOPS data. HC.RI.1 Total Pharmaceuticals expenditure (TPE) includes expenses incurred for treatment of members as inpatient, outpatient and expenses incurred on over the counter medicines.

Inpatient medical expenditure are captured in NSS-HS 71 under three headings: 1. Package component, 2. non-package component that includes doctor's fee, bed charges, diagnostics, drugs and others (blood, physiotherapy and allied etc), 3. Package component along with the additional expenditures on doctor's fee, medicines, diagnostics etc. Hence, to arrive at the total expenditure on drugs from the inpatient block, expenditure incurred on medicines under non-package components are added to the estimated expenditures for the package component.[60]

HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM) Medical expenses on Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy (AYUSH) includes the total medical expenditures when the nature of treatment was AYUSH from the inpatient, outpatient, ANC and PNC block from NSS-HS 71.

59 It was observed that expenditure on doctor's fee was reported even when the treatment was not taken on medical advice, such expenditure is reported as a part of outpatient curative care and classified as HC.1.3.nec Unspecified outpatient curative care (nec)

60 Pharmaceutical expenditure for package component is estimated using the ratios of expenditure on pharmaceuticals from the insurance claims data procured from Insurance Regulatory Development Authority of India (IRDAI).

5.1.4 Methodology to estimate out of pocket expenditures and development of allocation keys

Methodology to estimate household health expenditures includes understanding the method to derive estimates for expenditure line items from data sources and deriving the allocation keys where required, especially when one expenditure line item is mapped to multiple codes in the same classification. These steps are explained in the following sub-sections in detail.

Table 5.1.3: Mapping expenditure line items to SHA 2011 classification

Code	Expenditure Line items	FS	HF	HP	HC
HH01	Inpatient care	FS.6.1	HF.3.3	HP.1.1.1, HP.1.1.2, HP.3.4.9, HP.4.2, HP.5.1	HC.1.1.1, HC.1.1.2, HC.RI.1, HC.RI.2,
HH02	Outpatient care	FS.6.1	HF.3.3	HP.1.1.1, HP.1.1.2, HP3.1.1, HP.3.3, HP.3.4.9, HP.4.2, HP.5.1, HP.10	HC.1.3.1, HC.1.3.2, HC.1.3.3,HC.1.3.nec, HC.RI.1, HC.RI.2
HH03	Over the counter medicines	FS.6.1	HF.3.3	HP.5.1	HC.5.1.4, HC.RI.1, HC.RI.2
HH04	Laboratory and Imaging services (Diagnostics)[54]	FS.6.1	HF.3.3	HP.4.2	HC.4.4
HH05	Patient's transportation	FS.6.1	HF.3.3	HP.4.1	HC.4.3
HH06	Prenatal Care	FS.6.1	HF.3.3	HP.4.2,HP.5.1,HP.6	HC.6.4, HC.RI.1, HC.RI.2
HH07	Postnatal Care	FS.6.1	HF.3.3	HP.4.2, HP.5.1, HP.6	HC.6.4, HC.RI.1, HC.RI.2
HH08	Family Planning devices	FS.6.1	HF.3.3	HP.5.2	HC.5.2.4
HH09	Therapeutic appliances and Other medical goods	FS.6.1	HF.3.3	HP.5.2	HC.5.2.4
HH10	Immunization	FS.6.1	HF.3.3	HP.6	HC.6.2
HH11	Vitamins and Minerals	FS.6.1	HF.3.3	HP.5.1	HC.5.1.4

5.1.5 Methodology to derive estimates for expenditure line items from data sources

The expenditure line items for household health expenditures are derived from various data sources, which are predominantly data collected from surveys. The exact expenditures for these are derived using STATA statistical package version 14. The methodology presented in **Table 5.1.4** details on deriving the expenditures for each of the line items. Even though OOPS data can be calculated at aggregate levels, allocation ratios by healthcare functions and providers are calculated for the purpose of HAPT as described in **Table 5.1.5.** Important steps for estimations from surveys are given below:

1. Separate estimates are obtained for the categories of inpatient expenditure (HC.1.1), outpatient expenditure (HC.1.2), ante natal care (ANC) and post-natal care (PNC) expenditure (HC6.4) from NSS- HS 71 and for Urban and Rural Sector separately. These estimates are obtained as per capita expenditures for all ailments and all episodes during the reference period for inpatient care, outpatient care, ANC & PNC.
2. Missing values for any expenditure item were treated as zero.
3. Weighted aggregate expenditures for the various functional categories were estimated, using the combined sample weights.
4. Weighted aggregate reimbursements of medical expenditures by employers or insurance firms were estimated. Total medical reimbursements were subtracted for those individuals who had medical expenditures reimbursed. It was found that in some case, total reimbursement exceeds medical expenditure. This was possibly due to the reimbursements for transport which are not included as part of the medical expenditure or for incentives given for child birth. In all such cases reimbursement was imputed to be equal to medical expenditure.
5. For obtaining annualized values of OOP, inpatient care is taken as is, as it has been reported for a reference (recall) period for last 365 days and therefore no adjustment is needed for obtaining annual estimates. The OOPs for outpatient care has been reported for a reference (recall) period for

last 15 days and therefore adjustment is needed for obtaining annual estimates. Annual estimates for outpatient expenditures are obtained by multiplying the 15 day estimates by 365/15.

6. Mean per capita OOP was obtained by dividing the aggregate OOP in each functional category, by the total number of persons estimated from the sample. Aggregate OOP for the country was obtained by multiplying the per capita OOP estimates derived from NSSO survey with the population as on 1st April 2014 separately for rural and urban. Then using consumer price indices-health for rural (i.e CPI-Rural Labourers) and urban (i.e CPI-Industrial workers) separately OOPS was adjusted for the year 2013-14.
7. For calculating aggregate expenditure on therapeutic appliances and family planning, the per capita estimates from CES 68th round were multiplied by the population of the country as on January 1, 2012(midpoint of CES 68 whose survey period is July 2011-June 2012)and then extrapolated using relevant price indices for the year 2013-14.
8. For filling up NHA matrices, outpatient expenditure was to be cross tabulated with the providers; the detailed information of this was not available for outpatient expenditures from NSS-HS 71. Provider Classification of Outpatient Health Expenditures: NSS-HS 71 is designed in such a way that one block where the information is provided for level of care and another block where information is provided for expenditures incurred can be merged only for those individuals who are suffering from one ailment[61]. In order to obtain outpatient expenditure by level of care for all ailments, ratios of expenditures incurred by different types of healthcare providers are estimated by using data of only those persons who had single episode of treatment or single ailment. The total expenditure for each category of provider was then multiplied by the ratio of expenditure on all ailments to expenditure on one ailment, to reflect expenditure on all ailments.
9. For the cases where outpatient expenditure who had taken medical consultation, provider classification was missing, it was decided to classify it as HP.10 Other healthcare providers not elsewhere classified.
10. Expenditure on Prescribed drugs and OTC drugs: Similarly the prescribed and OTC expenditure on drugs can be obtained only for one ailment for outpatient expenditure. So all ailment OTC expenditure is estimated by multiplying one ailment OTC expenditure by the ratio of all ailment total outpatient expenditure to one ailment total outpatient expenditure. To evaluate this, ratios of expenditures incurred by different types of healthcare providers are estimated by using data of only those persons who had single episode of treatment or single ailment. These ratios are used to apportion the total outpatient health expenditures obtained above into different healthcare providers.
11. Immunization estimates are obtained from IMS data and added to total OOP expenditures obtained above.

5.1.6 Methodology for trend estimation of OOPs

For estimating the inter survey growth rate, compound annual growth rate[62] in health expenditure from health and morbidity survey rounds were used[63] as the CES growth rates overestimated the predicted OOP for 2013-14. These growth rates are estimated separately for different categories of expenditure:

61 Block 9 in NSS-HS 71 records expenditures for treatment person wise while Block 8 records the other details of the treatment spell wise. Hence, it cannot be merged for all ailments. For inpatient expenditures, there were no such limitations.

62 The compound rate of growth formula: $r = \left\{\left(\frac{P_t}{P_0}\right)^{\frac{1}{t}} - 1\right\} * 10$, where, P_t is the expenditure in the later time period, P_0 is the expenditure in the base year and it is the number of years

63 National Sample Survey Office: Social Consumption on health 60th round (NSS-HS 60 2004 and NSS-HS 71 2014)

1. Outpatient including expenditure on therapeutic appliances and pharmaceuticals.
2. Inpatient expenditure including expenditure on childbirth, medical attention at death, abortion & still birth).
3. Preventive care including expenditure on ANC, PNC, Immunization and Family planning.

The growth rate in OOP for states is estimated as the compound growth rate between the different components of health expenditure separately for rural and urban.

Table 5.1.4: Methodology to derive estimates for each expenditure line item

Code	Expenditure Line Items	Data Source	Methodology
HH01	Inpatient care	NSS-HS 71, Schedule-25, Block-7	Package component (Item 7.5) + Non Package component {Doctor's/surgeon's fee (item 7.6) + medicines (Item 7.7)+ diagnostics (item 7.8)+ Bed Charges (7.9) +Other medical expenses (7.10)} - total amount reimbursed by medical insurance company or employer (Item 7.15).
HH02	Outpatient care	NSS-HS 71, Schedule-25, Block 8 & Block 9	According to Item 8.13, when treatment is taken on medical advice is 'yes' i.e. code 1 is reported then outpatient curative care expenditures includes Doctors' fee (Item 9.9) + medicines: AYUSH (Item 9.10) +medicines: other than AYUSH (Item 9.11) +diagnostic tests (Item 9.12) + other medical expenses (attendant charges, physiotherapy, personal medical appliances, blood, oxygen etc.) (Item 9.14)P} - total amount reimbursed by medical insurance company or employer (Item 9.18). According to Item 8.13, when treatment is taken on medical advice is 'no' i.e. code 2 is reported, then expenditures under the components such as doctor's fee and other medical expenditures are treated as HH02 (Outpatient curative care). The expenditure for outpatient care has been reported for a reference (recall) period for last 15 days in the survey and therefore adjustment is needed for obtaining annual estimates. Annual estimate or the total outpatient expenditure estimate for a particular year is obtained by multiplying the 15-day estimates by 365/15.
HH03	Over the counter medicines	NSS-HS 71, Schedule-25, Block 8 & Block 9	According to Item 8.13, when treatment is taken on medical advice is 'no' i.e. code 2 is reported, then expenditure incurred on medicines: AYUSH (Item 9.10) + medicines: other than AYUSH (Item 9.11) under whom consulted (item 8.17) i.e. self/relatives/ friends or medicine shops or others are treated as expenditures on Over the counter medicines
HH04	Laboratory and Imaging services (Diagnostics)[54]	NSS-HS 71, Schedule-25, Block 8 & Block 9	According to Item 8.13, when treatment taken on medical advice is 'no' i.e. code 2 is reported. Expenditure incurred on diagnostic tests (Item 9.12) under whom consulted (item 8.17) i.e self/ relatives/friends or medicine shops or others are treated as expenditures on diagnostics (Code: HH04)
HH05	Patient's transportation	NSS-HS 71, Schedule-25 Block 7 & Block 9	Expenditure incurred on Patient's transport (Item 7.12) + (Item 9.15)
HH06	Prenatal Care	NSS-HS 71, Schedule-25 Block 11	Total expenditure incurred on prenatal care (Item 11.9)
HH07	Postnatal Care	NSS-HS 71, Schedule-25 Block 11	Total expenditure incurred on postnatal care (Item 11.14)
HH08	Family Planning	National Family Health Survey-4: Man's Questionnaire Section 3;	Expenditure on sterilization including any consultation (Item 307)-Compensation (Item 309) {if received compensation for sterilization (Item 308=1)} + Expenditure on condoms and the cost of the method and any consultation (Item 527)
		National Family Health Survey-4: Woman's Questionnaire, Section 3B	Expenditure on sterilization including any consultation (Item 335)-Compensation(Item 337) {if received compensation for the sterilization (Item 336=1),
		Consumer Expenditure Survey 68th Round: Schedule 1.0, Schedule type 1	Expenditure on Family planning devices (Item 10.423)

Code	Expenditure Line Items	Data Source	Methodology
HH09	Therapeutic appliances and Other medical goods	Consumer Expenditure Survey 68th Round: Schedule 1.0, Schedule type 1	Therapeutic appliances: sub-total (610-611) (Item 11.619) Note: CES 68 is the data source for estimation of expenditure on therapeutic appliances. The item, medical expenses for attendant charges, physiotherapy, personal medical appliances, blood, oxygen, etc. (i.e. item 7.10 and Item 9.13) in NSS-HS 71 also includes a part of the expenditure on therapeutic appliances, which is medically recommended. While estimating expenditure on therapeutic appliances from CES 68, only those individuals who have incurred expenditure on therapeutic appliances (Item 11.619) but have not incurred expenditures under institutional care (item 10.419) or non-institutional care (item 10.429) are included. This is done in order to avoid double counting of expenditure under this category across the two surveys.
HH10	Immunization	Intercontinental Marketing Services- Health database for India – Pharma track data	
HH11	Vitamins and minerals	Intercontinental Marketing Services- Health database for India – Pharma track data	

Table 5.1.5: Classifications and allocation formula to derive estimates for each expenditure line item

Code	Expenditure Line items	HF	FS	HP	HC	Allocation Formula
HH01	Inpatient care	HF.3.3	FS.6.1	HP.1.1.1, HP.1.1.2, HP.3.4.9, HP.4.2, HP.5.1	HC.1.1.1, HC.1.1.2, HC.RI.1, HC.RI.2	1. HP.1.1.1, HP.1.1.2, HP.3.4.9, HP.4.2 and HP.5.1 are to be divided into the ratios that are calculated using the proportion of expenditure of each provider in inpatient health expenditures from NSS-HS 71. 2. HC.1.1.1, HC.1.1.2 are then to be divided in the ratios of inpatient health expenditures calculated by classifying as generalized and specialized care on the basis of nature of ailment
HH02	Outpatient care	HF.3.3	FS.6.1	HP.1.1.1, HP.1.1.2, HP3.1.1, HP.3.3, HP.3.4.9, HP.4.2, HP.5.1, HP.10	HC.1.3.1, HC.1.3.2, HC.1.3.3. HC.1.3.nec, HC.RI.1, HC.RI.2	1. HP.1.1.1, HP.1.1.2, HP.3.1.1, HP.3.3, HP.3.4.9, HP.4.2, HP.5.1 and HP.10 are to be divided into the ratios that are calculated using the proportion of expenditure of each provider in outpatient health expenditures from NSS-HS 71. 2. HC.1.3.1, HC.1.3.2, HC.1.3.3 and HC.1.3.nec are then to be divided in the ratios of outpatient health expenditures calculated by classifying as generalized and specialized care on the basis of nature of ailment
HH03	Over the counter medicines	HF.3.3	FS.6.1	HP.5.1	HC.5.1.4, HC.RI.1, HC.RI.2	
HH04	Laboratory and Imaging services (Diagnostics)	HF.3.3	FS.6.1	HP.4.2	HC.4.4	
HH05	Patient's transportation	HF.3.3	FS.6.1	HP.4.1	HC.4.3	

Code	Expenditure Line items	HF	FS	HP	HC	Allocation Formula
HH06	Prenatal (antenatal) Care	HF.3.3	FS.6.1	HP.4.2, HP.5.1, HP.6	HC.6.4, HC.RI.1, HC.RI.2	All expenditures under this item are not dis aggregated in the survey and hence allocated into providers HP.4.2, HP.5.1 and HP.6 as calculated from the ratios used to allocate outpatient expenditures (for diagnostics, drugs and other outpatient services)
HH07	Postnatal Care	HF.3.3	FS.6.1	HP.4.2, HP.5.1, HP.6	HC.6.4, HC.RI.1, HC.RI.2	All expenditures under this item are not dis aggregated in the survey and hence allocated into providers HP.4.2, HP.5.1 and HP.6 as calculated from the ratios used to allocate outpatient expenditures (for diagnostics, drugs and other outpatient services)
HH08	Family Planning devices	HF.3.3	FS.6.1	HP.5.2	HC.5.2.4	
HH09	Therapeutic appliances and Other medical goods	HF.3.3	FS.6.1	HP.5.2	HC.5.2.4	
HH10	Immunization	HF.3.3	FS.6.1	HP.6	HC.6.2	
HH11	Vitamins and Minerals	HF.3.3	FS.6.1	HP.5.1	HC.5.1.4	

Annexure 5.1

Diseases classified into generalized and specialized care interpreted from SHA 2011 classifications

Generalized Care	Specialized Care
Fever with rash/ eruptive lesions	Fever with loss of consciousness or altered consciousness
All other fevers (Includes malaria, typhoid and fevers of unknown origin, all specific fevers that do not have a confirmed diagnosis)	Fever due to diphtheria, whooping cough
Anemia(any cause)	Filariasis
Under-nutrition 17	Tuberculosis
Headache	Tetanus
Seizures or known epilepsy	HIV/AIDS
Discomfort/pain in the eye with redness or	Other sexually transmitted diseases
swellings/ boils	Jaundice
Cataract	Diarrheas/ dysentery/ increased frequency of stools with or without blood and mucus in stools
Glaucoma	Worms infestation
Decreased vision (chronic) not including where decreased vision is corrected with glasses	Cancers (known or suspected by a physician) and occurrence of any growing painless lump in the body
Earache with discharge/bleeding from ear/ infections	Bleeding disorders
Decreased hearing or loss of hearing	Diabetes
Hypertension	Goiter and other diseases of the thyroid
Acute upper respiratory infections (cold, runny nose, sore throat with cough, allergic colds included)	Others (including obesity)
Cough with sputum with or without fever and not diagnosed as TB	Mental retardation
Pain in abdomen: Gastric and peptic ulcers/ acid reflux/ acute abdomen	Mental disorders
Skin infection (boil, abscess, itching) and other skin disease	Weakness in limb muscles and difficulty in movements
Joint or bone disease/ pain or swelling in any of the joints, or swelling or pus from the bones	Stroke/ hemiplegic/ sudden onset weakness or loss of speech in half of body
Back or body aches	Others including memory loss, confusion
Accidental injury, road traffic accidents and falls	Others (including disorders of eye movements – strabismus, nystagmus, ptosis and adnexa)
Accidental drowning and submersion	Heart disease: Chest pain, breathlessness
Burns and corrosions	Bronchial asthma/ recurrent episode of wheezing and breathlessness with or without cough over long periods or known asthma)
Poisoning	Lump or fluid in abdomen or scrotum
Intentional self-harm	Gastrointestinal bleeding
Assault	Any difficulty or abnormality in urination
Contact with venomous/harm-causing animals and plants	Pain the pelvic region/reproductive tract infection/ Pain in male genital area
Symptom not fitting into any of above categories	Change/irregularity in menstrual cycle or excessive bleeding/pain during menstruation and any other gynecological and anthological disorders incl. male/ female infertility
Could not even state the main symptom	Pregnancy with complications before or during labour (abortion, ectopic pregnancy, abortion, hypertension, complications during labour)
Child birth	Complications in mother after birth of child
Dental Outpatient Care	Illness in the newborn/sick newborn
Diseases of mouth/teeth/gums	

5.2 Health Expenditure by Enterprises

In this section, methodology to estimate health expenditures by enterprises for India using the system of health accounts 2011 (SHA 2011) is presented. Enterprises, both public and private together spend 5.2% of India's total health expenditure[64]. Enterprises usually finance and provide healthcare services to their employees and their dependents. They do this either by reimbursing the medical bills of the employees and dependents; they directly provide healthcare services through their own clinics and hospitals; purchase group insurance on behalf of the employees through an insurance company; or just pay annual lump sum monetary benefit to employees as part of their salary package regarded as a medical benefit.

5.2.1 Data sources for estimating expenditures by enterprises for NHA

There is no standard mechanism to report the health expenditure by the enterprise on a regular basis. Ministry of Corporate Affairs (MOCA) keeps detailed data on enterprises expenditures. However the data on health expenditures are difficult to estimate from the data on total employee benefits, hence the survey methodology was used for this NHA. The data on corporate social enterprises are broken up in the MOCA data base and can be used to triangulate the health expenditures under CSR in the surveys with those obtained from MOCA.

For institutionalization, a standard procedure for getting the data from enterprises – both public and private through Ministry of Corporate Affairs (MOCA) or regular surveys through NSSO is a way forward. A standalone survey of the enterprises (public and private) can be used to compile the data on enterprises, which has also been done for NHA 2013-14. The methodology of the survey for firms' data for 2013-14 is given below in the annexure at the end of this chapter. The format used in the survey is attached at the end of the report under A2.

5.2.2 Boundaries for health expenditures by enterprises

All expenditures except the lump sum payments are considered as health expenditure for NHA. It is difficult to establish the exact purpose of these lump sum payments. The employee households might use it for various purposes. Further, expenditure under the Corporate Social responsibility funding by enterprises for health purposes is included as part of the health spending.

5.2.3 Mapping and classifications of enterprises health expenditures within SHA 2011 framework

According to the SHA 2011 Framework, health expenditures by enterprises in India are mapped to their respective classification and codes as given below in **Table 5.2.1.** Health expenditures by enterprises are classified under the health financing scheme - Enterprises (except healthcare providers) financing schemes (HF.2.3.1) and the revenue of financing scheme are classified as Other revenues from corporations nec(FS.6.1). Expenditure line items from enterprises can be classified as shown in Table 5.2.1.

Table 5.2.1: Identifying health expenditure by enterprises to SHA 2011 framework and classifications

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.2.3 Enterprise financing schemes
	HF.2.3.1 Enterprises (except healthcare providers) financing schemes
	HF.2.3.1.1 Public enterprises (except healthcare providers) financing schemes
	HF.2.3.1.2 Private enterprises (except healthcare providers) financing schemes
Revenue of financing scheme (FS)	FS.6 Other domestic revenues i.e. - FS.6.1 Other revenues from corporations nec

64 Report of the National Commission on Macroeconomics and Health (2005), Ministry of Health and Family Welfare, Government of India.

SHA 2011 Classification categories	SHA 2011 classification and code
Healthcare Providers (HP)	HP.1 Hospitals: HP.1.1.2 General hospitals – Private, HP.1.3.2 Specialised hospitals (other than mental health hospitals) – Private HP.3.1.1 Offices of general medical practitioners (Private) HP.3.1.3 Offices of medical specialists (other than mental medical specialists) (Private) HP.4.1 Providers of patient transportation and emergency rescue HP.4.2 Medical and diagnostic laboratories HP.6 Providers of preventive services; HP.10 Other providers not elsewhere classified
Healthcare Functions (HC)	HC.1.1 Inpatient curative care, HC.1.1.1 General inpatient curative care, HC.1.1.2 Specialized inpatient curative care, HC.1.3 Outpatient curative care; HC.1.3.1 General outpatient curative care, HC.1.3.3 Specialized outpatient curative care; HC.4.3 Patient transportation HC.4.4 Laboratory and imaging services HC.6 Preventive care;HC.6.1.nec Unspecified preventive care (nec);

5.2.4 Classification and mapping

The concordance of enterprise expenditure on health with SHA 2011 system is given in **Table 5.2.2** below.

Table 5.2.2: Mapping Expenditure line items for enterprises to SHA 2011 classifications

Code	Description	FS	HF	HP	HC
EN001	Reimbursement (OP)	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN002	Reimbursement (IP)	FS.6.2	HF.2.3.1.2	HP.1.1.2	HC.1.1.1
EN003	Health awareness workshops/camps, etc. for employee only	FS.6.2	HF.2.3.1.2	HP.6	HC.6.1.nec
EN004	On-site doctor on call - OP	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN005	Dispensaries	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN006	Hospitals – IP	FS.6.2	HF.2.3.1.2	HP.1.1.2	HC.1.1.1
EN007	Hospitals – OP	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN008	Hospitals - day Care	FS.6.2	HF.2.3.1.2	HP.1.1.2	HC.1.1.1
EN009	Preventive programs	FS.6.2	HF.2.3.1.2	HP.6	HC.6.1.nec
EN010	Other OP	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN011	CSR (Spending on Health)	FS.6.2	HF.2.2.1	HP.10	HC.9
EN012	Dispensary with medical personnel other than doctor	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN013	Dispensary with general doctor	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN014	Dispensary/Clinic with specialists	FS.6.2	HF.2.3.1.2	HP.1.3.2	HC.1.3.1, HC.1.3.3
EN015	General hospital – IP	FS.6.2	HF.2.3.1.2	HP.1.1.2	HC.1.1.1
EN016	General hospital – OP	FS.6.2	HF.2.3.1.2	HP.3.1.1	HC.1.3.1
EN017	General hospital - Day care	FS.6.2	HF.2.3.1.2	HP.1.1.2	HC.1.1.1
EN018	Multi-Specialty hospital - IP	FS.6.2	HF.2.3.1.2	HP.1.3.2	HC.1.1.1, HC.1.1.2, HC.1.3.3, HC.1.3.1
EN019	Multi-Specialty hospital - OP	FS.6.2	HF.2.3.1.2	HP.3.1.3	HC.1.3.3, HC.1.3.1
EN020	Multi-Specialty hospital - day Care	FS.6.2	HF.2.3.1.2	HP.1.3.2	HC.1.1.1, HC.1.1.2
EN021	Single specialty hospital - IP	FS.6.2	HF.2.3.1.2	HP.1.3.2	HC.1.1.1, HC.1.1.2
EN022	Single specialty hospital - OP	FS.6.2	HF.2.3.1.2	HP.3.1.3	HC.1.3.3, HC.1.3.1
EN023	Single specialty hospital - day Care	FS.6.2	HF.2.3.1.2	HP.1.3.2	HC.1.1.2
EN024	Diagnostic – Laboratory	FS.6.2	HF.2.3.1.2	HP.4.2	HC.4.4
EN025	Diagnostic – Imaging	FS.6.2	HF.2.3.1.2	HP.4.2	HC.4.4
EN026	Ambulances (Patient Transport)	FS.6.2	HF.2.3.1.2	HP.4.1	HC.4.3

5.2.5 Estimation and blow up strategy

Using the survey data, expenditure on health benefits per employee has been estimated. Keeping in mind the requirements of system of health accounts, these estimated figures have been further broken up into different ways through which this expenditure was made. In case of expenditure on corporate social responsibility and enterprises' own facilities, per unit expenditure has been estimated.

Fifth economic census has been used as first step of blow up of sample estimates for private enterprises. Public sector units, non profit institutions and unincorporated units have been left out from the universe of units listed in fifth economic census. This exercise has been carried out for primary, secondary and tertiary sectors separately. Employment size from the census and sample estimates of expenditure per employee have been used to arrive at total expenditure on employees' health benefits for these three sectors separately. Employment figures from Department of Public Sector Enterprises (DPE), Government of India and state audited reports from Comptroller General Audit, Government of India have been used in case of public sector units.

Sample estimates of per employee expenditure on each type of health facility have been blown up using employment figures obtained from NSSO survey on employment and unemployment. All regular employees who have some written contract constitute the universe of employment. Since the latest employment data is available for 2011-12, this employment figure has been adjusted using the ratio of population as per NSSO and projected census population for 2013-14.

For estimating firms' expenditure on corporate social responsibility (CSR) and their own health facilities, economic census data has been used. Sample estimates of per unit expenditure have been blown up using number of establishments which have greater than twenty hired employees and their type of ownership is either private corporate non- financial enterprises, private corporate financial enterprises or private co-operative enterprises.

Ministry of Corporate Affairs (MOCA) also keeps detailed data on enterprises expenditures. However the data on health expenditures are difficult to estimate from the data on total employee benefits, hence the survey methodology was used for this NHA. The data on corporate social enterprises are broken up in the MOCA data base and can be used to triangulate the health expenditures under CSR in the surveys with those obtained from MOCA.

Annexure 5.2

Survey Methodology

A survey of enterprises has been conducted for this purpose. The survey schedule is given as A2 at the end of the guidelines. Data has been collected from a sample of 1987 establishments distributed across the 19 states.

Two separate frames have been used for public sector units and private enterprises. List of PSUs was obtained from Department of Public Sector Enterprises (DPE), Government of India in case of central PSUs and state audited reports from Comptroller General Audit, Government of India in case of state PSUs. Prowess data set from CMIE has been used as frame for private enterprises.

Having determined the state wise sample size for private enterprises, sample has been further distributed proportionally among primary, secondary and tertiary sectors within each state.

After retaining enterprises only from the 19 states out of the CMIE enterprises' list, we arrived at a curtailed list of nearly 24,000 enterprises. This covers more than 80 percent of all the companies listed in CMIE. Corporate offices of private enterprises are highly concentrated in a few states such as Maharashtra, Delhi NCR, West Bengal and Tamil Nadu etc. This led to sample size for some of the smaller states turning out to be very low. Adjustments have been made in the sample distribution to keep a minimum of 30 sample enterprises in each of these states. Remaining sample out of total 1800 has been further distributed proportionally among the remaining states.

PSU sample units were selected based on distribution of public sector units across the 19 states of our interest. Some adjustments were made to ensure representation of all these states in the PSU sample.

5.3 Health Expenditure by Non-Profit Institutions Serving Households (NPISH)

The key role of non-governmental/not-for-profit/voluntary sector in health system of the country involves (a) provider of healthcare services through own facilities, (b) financing agent to manage several healthcare schemes, and (c) run own health financing schemes. There were about ten health oriented projects in recent past by the central ministry of Health and Family Welfare, where NGOs have been actively taken part as health service provider to financing agent (fund management) based on their level of capacity (for instance, Mother-NGO Scheme). All the NGO-schemes are now under provision of the flexi pools in National Health Mission of concerned state. Besides, some NGOs (especially the Indian counterpart of international NGOs, faith-based organizations, etc.) might have their own health financing schemes.

In this section, methodology to estimate health expenditures by NPISH for India is presented. The non-profit institutions are commonly known as non-governmental organizations (NGOs) which are the legal organizations and not allowed to distribute any profit, by law or custom, to those who own or control it, and institutionally separate from government, are self-governing and noncompulsory. They operate in different sectors like education, health, sports, recreation, culture, and religious and so on in mutually non-exclusive ways. The NPISH finances health services directly from their own revenues or from the grants received from governments, enterprises and external donors. They deliver services through their own clinics, hospitals and community health workers.

5.3.1 Data sources for health expenditure by NPISH

There is no standard mechanism to report the health expenditure by NPISH on a regular basis. FCRA and OECD CRS data base has information on funds utilized and disbursed by external donors to Nonprofit organisations. These have been explained in the chapter on external resources and can be used to triangulate other data obtained from the survey. A survey of the NPISH is the only way to compile the data on NPISH own revenues, or revenues received from other sources (excluding external donors) and for understanding the utilization of funds received for health services.

There is almost no official secondary database available that can be used to estimate and analyze NGOs' role for NHA/SHA matrices. The recent official information (NSSO 67th Round, 2010-11) cover 234 sample health-NGOs and are likely to provide less reliable estimate especially at state levels of health expenditure by NGOs. This data can however, be used at national level. So, a primary survey was carried out to estimate the NPISH expenditures. The survey design uses official directory information on NGOs as base frame-population[65]. The survey methodology is shown in Annexure 5.3. and the survey tool is given in annexure A3 at the end of the guidelines.

The survey recognizes 'mixed' **areas** of their operation as described above and there are three categories defined in line with the scope of study. First, those exclusively/primarily involved in health sector. Second, those operated in health sector on subsidiary basis. Rest are the last category which may hardly be associated with direct health activities, and hence getting least importance in the study.

1. NGOs-coverage under study– purposively, the health sector NGOs are considered here into two groups. **Group-1** is *primary-health NGOs*, a set of NGOs exclusively/primarily involved in health sector activities, and they are the prime interest in this study. **Group-2** is *subsidiary-health NGOs*, those operated in health sector activities in subsidiary/auxiliary basis. **Group-3** is the *non-health NGOs*, which may occasionally be engaged in health activity or simply provide health benefits to their own employees.
2. Role of health-NGOs– there are three possible ways that the health-NGOs may operate in health sector. First, they directly function as provider of health services. Second, their role may be indirect such as health awareness building, advocacy and R&D activities. Finally, they may act as funding agent (intermediary source of health financing) or/and financing scheme (primary source of health sector finance).

5.3.2 Boundaries for health expenditures by NPISH

It covers all expenditures as defined in the boundary chapter, however care has to be taken to exclude non-health activities captured in the line items.

65 Information on Sampling design, frame, allocation of weights etc is given in the annexure.

5.3.3 Describing NPISH health expenditures within SHA 2011 framework

According to the SHA 2011 framework, health expenditures by NPISH in India are mapped to their respective classification and codes as given in **Table 5.3.1.** Health expenditures by NPISH are classified under the health financing scheme - NPISH financing schemes (excluding HF.2.2.2.) are included under HF.2.2.1 and the revenue of financing scheme are classified as other revenues from NPISH.nec (FS.6.3). NPISH usually provide curative, rehabilitative and preventive services to the target population. Functional classifications and provider classification for NPISH are shown below.

Table 5.3.1: Identifying health expenditure by NPISH to SHA 2011 framework and classifications

SHA 2011 Classification categories	SHA 2011 classification and code
Health financing Scheme (HF)	HF.2 Voluntary healthcare payment schemes (other than Household out-of-pocket payments) HF.2.2 NPISH financing schemes HF.2.2.1 NPISH financing schemes (excluding HF.2.2.2)
Revenue of the financing scheme (FS) Institutional unit and financing agent	FS.6 Other domestic revenues FS.6.3 Other revenues from NPISH.nec
Healthcare Providers (HP)	HP.1.1.2 General hospitals - Private HP.1.3.2 Specialised hospitals (Other than mental health hospitals)-Private HP.3.1.1 Offices of general medical practitioners (Private) HP.4.2 Medical and diagnostic laboratories HP.6 Providers of preventive care HP.6.nec Unspecified preventive care (nec) HP.7 Providers of healthcare system administration and financing(HP.7) HP.7.9 Other health administration agencies.
Healthcare Functions (HC)	HC.1.1 Inpatient curative care - HC.1.1.1 general; HC.1.1.2 specialized HC.1.3 Outpatient curative care - HC.1.3.1 general, HC.1.3.3 specialized HC.2.nec All Rehabilitative care HC.4 Ancillary services (non-specified by function); HC.4.4 Laboratory and Imaging services; HC.6 Preventivecare; HC.6.1.nec – IEC programs (nec) HC.6.2 Immunisation programs, HC.6.3 Early disease detection programs, HC.6.4 Healthy condition monitoring programs HC.7.2 Administration of health financing

5.3.4 Mapping and classifications of health expenditures by NPISH within SHA 2011 framework

The major line items of NPISH sources of revenues and expenditures have been identified from the survey and are classified according to SHA 2011 codes developed for India.

Table 5.3.2: Mapping expenditure line items of health expenditures by NPISH to SHA 2011 classification

Code	Description	FS	HF	HP	HC
NG001	Multispecialty Hospital (including MC)	FS.6.3	HF.2.2.1	HP.1.3.2	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.1.3.3
NG002	Single Specialty Hospital	FS.6.3	HF.2.2.1	HP.1.3.2	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.1.3.3
NG003	General Hospital	FS.6.3	HF.2.2.1	HP.1.1.2	HC.1.1.1, HC.1.3.1
NG004	Clinic for rehabilitative and long-term care	FS.6.3	HF.2.2.1	HP.3.1.1	HC.2.nec
NG005	Clinic or dispensary for outpatient care (OPD only)	FS.6.3	HF.2.2.1	HP.3.1.1	HC.1.3.1
NG006	Clinic for ancillary services like lab and/or image tests, ambulance	FS.6.3	HF.2.2.1	HP.4.2	HC.4.4
NG007	Non-clinical medical support like management/ financial help	FS.6.3	HF.2.2.1	HP.7.1	HC.7.2
NG008	Awareness campaigns, enrolment drives, etc.	FS.6.3	HF.2.2.1	HP.6	HC.6.1.nec
NG009	Health camps for surgical procedures	FS.6.3	HF.2.2.1	HP.6	HC.1.3.1
NG010	Health camps for diagnostics and general check-up of community/targeted groups	FS.6.3	HF.2.2.1	HP.6	HC.6.3
NG011	Child immunization programmes	FS.6.3	HF.2.2.1	HP.6	HC.6.2
NG012	Blood Donation Camp	FS.6.3	HF.2.2.1	HP.6	HC.1.3.1
NG013	Antenatal and/or postnatal care of women (ANC/PNC)	FS.6.3	HF.2.2.1	HP.6	HC.6.4

Annexure 5.3

Survey Methodology

As per the survey design, samples are drawn at all-India level for each group and distributed across 18 major states as per the concentration of health NGOs: Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Odisha, Punjab, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh, West Bengal and Delhi.

Sample size is determined for each group separately as per the importance of study. Since primary-health NGOs are expected to play the key role from provider of healthcare services to primary source of healthcare revenues, a more intensive sample plan is designed; the study covers all large primary-health NGOs and samples are drawn at 3% margin of error in 95% confident interval from the rest primary-health NGOs comprising micro/small/medium size, and then distributed proportionally at different stages of stratification (across states, and then size-based strata). A moderate level of samples are drawn (5% margin of error in 95% confident interval) for the subsidiary-health NGOs and distributed accordingly. Since the large and medium NGOs are merely considered for non-health NGOs, samples are drawn at 10% margin of error in 95% confident interval for them. A multi-stage stratified random sampling is designed for surveying the NGOs. About 1800 samples are drawn for the survey.

While the samples in each stratum are drawn randomly without replacement, we are ensuring at least thirty samples in each selected states and a minimum quota of two samples in each size based stratum for standard statistical analysis. Further, a particular stratum may be absent in the samples because none of the NGOs are operating in such stratum. Finally, if any non-response arises, the replacement is allowed with similar characteristics.

The 'blow-up strategy' from sample statistics (sample mean and ratio) used CSO-NAD Census information as sixth economic census was not available. The weighting patterns for aggregation as well as ratio estimate at state/national level are designed separately for respective groups of NGOs.

CHAPTER 6

Health Insurance Expenditures

This chapter consolidates detailed information of data sources, boundaries, SHA 2011 classifications, codes and methodology to estimate health insurance expenditures for India.

Health insurance schemes in India are presented in Section 6.1; their data sources in Section 6.2; boundaries in Section 6.3; mapping expenditure line items to the SHA 2011 classifications and codes in Section 6.4; allocation keys for expenditure line items with multiple sources of revenue, providers or healthcare functions in Section 6.5. Compilation of health insurance expenditure line items for analysis using the health accounts production tool (HAPT) to arrive at NHA estimates is explained in chapter 8 of these guidelines.

6.1 Health Insurance Schemes in India

Health insurance is defined as health financing arrangement that involves distribution of financial risk associated with the variation of individual's healthcare expenditures by pooling costs over time (prepayment) and over people[66]. Health insurance serves as a means to protect households from the risk of medical expenses that can be large, relative to modest incomes[67]. The institution that performs this risk pooling function is an insurer. Insurer can be a private or government entity.[68] Private entity as an insurer essentially entitles coverage through household payments in the form of premium/contributions. In contrast, government health insurance is generally funded through payroll or income taxes and general government revenues. All expenditures that fall within this flow of funds among these institutions are considered health insurance expenditures.

For purpose of National Health Accounts, health Insurance in India encompasses health-financing schemes financed by contributions/premiums collected from individuals or governments and pooled to actively purchase services from healthcare providers either by government (health department or government governed corporation/trust/society) and/or insurance company. According to System of Heath Accounts 2011 expenditures of these five types of health financing schemes are considered as health insurance expenditures in India.

1. Social health Insurance
2. Government based voluntary insurance
3. Employer based insurance (other than enterprises schemes)
4. Other primary coverage schemes (Individual voluntary health insurance)
5. Community based insurance

66 Tapay, N., and F. Colombo, eds. 2004. Private Health Insurance in OECD Countries OECD: Paris.

67 Van Doorslaer, E. et al, 2007. Catastrophic payments for healthcare in Asia. Health Economics 16, 1159-1184.

68 Claxton, G. and J. Lundy. 2008. "How Private Health Coverage Works: A Primer 2008. Brunner G. et al.2012. Private Voluntary Health Insurance Consumer Protection and Prudential Regulation. The World Bank, Washington DC.

What is not considered as health insurance expenditures?

- Medical reimbursements by government to its employees, for example Civil Servants Medical Attendance scheme for central government employees is considered as Government Employee Schemes according to SHA 2011 and not health insurance
- State government reimbursements of medical bills to its own employees under "'object head (06) medical treatment/ reimbursement'' is considered as Government Employee Schemes according to SHA 2011 and not health insurance

Union government and state governments have 'medical relief funds or medical emergency funds' paid on request to below poverty line/ vulnerable populations for tertiary care medical treatment across India. The respective department/state governments have their own mechanisms of processing such requests. One common mechanism is through recommendations of the members of parliament and members of state legislative assemblies and councils or by the discretion of the chief minister. All such payments made by the government are captured in the respective department budgets for specific financial year and will be captured and classified as government expenditures (non- employee schemes) and are not considered as insurance expenditures.

Important to note:

1. Considering the dynamic nature of health systems and financing reforms in the country and the states, the list of insurance schemes under each category given here is only indicative.
2. Financing schemes that fit the definition of health insurance as given in the guidelines or according to the system of health accounts can be further added to this list.
3. The classification and coding have to be done as required adhering to principles given in the guidelines and the System of Health Accounts.
4. It is recommended to reconsider the list of insurance schemes and the category they fall under every year NHA is conducted and changes be made to make it relevant and comparable to the earlier NHA estimates.
5. It is also important to note that while arriving at health insurance expenditure estimates, expenditures of all the insurance schemes might not be available due to discontinuation of the scheme or nascent stage of the scheme where expenditures might not fall under the financial year for which estimates are being generated.
6. At times expenditures for a particular scheme are unavailable or cannot be disaggregated from a particular data source. In such cases the chapter on estimates should clearly mention which schemes have been considered for health insurance expenditures in that particular year and the reason for not including other insurance schemes for estimates. This avoids double counting or underestimating the expenditures.

6.1.1 Social health insurance schemes

Social health insurance schemes have a financing arrangement that ensures access to healthcare based on a payment of a non-risk-related contribution by or on behalf of the eligible person. Contributions are mainly wage-related and are shared between employers and employees and/or by the government to cover deficits. The social health insurance scheme is established by a specific public law, defining, among others, the eligibility, benefit package and rules for the contribution payment. However it is not mandatory for the eligible persons to enroll in the program. (Refer Page 169 -171 in **SHA 2011** for further details).

The following schemes are categorized as social health insurance schemes in India - Central Government Health Scheme (CGHS) implemented by the Ministry of Health and Family Welfare; Employee State Insurance scheme (ESIS) implemented by the Employee State Insurance Corporation; Ex-servicemen Contributory Health Scheme (ECHS) of the Defence Services; Contributory Health Service Scheme (CHSS) of Department of Atomic Energy; Retired Employees Liberalized Health Scheme (RELHS) of the Indian Railways.

6.1.2 Government based voluntary insurance schemes

Schemes financed and implemented by the Union and State governments in order to provide cashless secondary and tertiary inpatient care services for specific groups of the population (below poverty line and unorganized sector workers). However in all schemes the participation by the population is voluntary. These schemes are implemented either through a government department, para-statal body governed by the government (Trust/ Society) or an insurance company. When implementation is only through a para-statal body, the entity receives a budgetary transfer from government for the reimbursements to be made to healthcare providers. However when an insurance company is used for implementation, premium is paid on behalf of the enrolled by the government (contributions are not collected from the enrolled population). For example, RSBY, Comprehensive health insurance scheme in Tamil Nadu and Jeevandayee scheme in Maharashtra use an insurance company for implementation. At times the enrolled population has to pay a minimal registration fee (in RSBY) or the enrolled population pays a part of /subsidized premium (the Handloom Weavers Scheme, Mizoram health Scheme for APL population, CHIS Kerala for APL population). (Refer Page 169 -174 **in SHA 2011** for further details). The following schemes are categorized as Government Based Voluntary Health Insurance schemes in India:

1. Rashtriya Swasthya Bima Yojana (RSBY)
2. Health Insurance for Handloom Weavers
3. Rajiv Aarogyasri (United Andhra Pradesh)/ NTR Vaidya Seva (Andhra Pradesh), Aarogyasri Scheme (Telangana)
4. Vajpayee Aarogyashree scheme and Rajiv Aarogya Bima scheme (Karnataka)
5. Yeshasvini scheme (Karnataka)
6. Comprehensive Health Insurance Scheme (CHIS) and CHIS Plus scheme (Kerala)
7. Comprehensive Health Insurance Scheme (Tamil Nadu)
8. Rajiv Jeevandayee Aarogya Yojana (Maharashtra)
9. Mukhyamantri Amrutam Yojana (Gujarat)
10. Biju Krushak Kalyan Yojana (BKKY) (Odisha)
11. Bhamashah Swasthya Bima Yojana (Rajasthan)
12. Bhagat Puran Singh Sehat Bima Yojana (Punjab)
13. Himachal Pradesh Swasthya BimaYojana (RSBY Plus) (Himachal Pradesh)
14. Mukhyamantri Swasthya Bima Yojana (Chhattisgarh)
15. Mukhyamatri Swasthya Bima Yojana (Uttarakhand)
16. Chief Ministers Universal Health Insurance Scheme (Arunachal Pradesh)
17. Mizoram State Healthcare Scheme (Mizoram)
18. Megha Health Insurance Scheme (Meghalaya)
19. Community health insurance scheme (Puducherry)
20. Goa Mediclaim Scheme (Goa)
21. Sanjeevani Swasthya Bima Yojana (Dadarand Nagar Haveli)

6.1.3 Employer based voluntary health insurance (other than enterprises schemes)

Voluntary group insurance provided by any of the 26 insurance companies (4 public and 22 private) in India that sell health insurance policies to enterprises falls under this category. This is a type of insurance purchased by employers, through a contract between the employer (the company) and the insurance company. The services provided are comprehensive inpatient care services with some policies covering health checkups annually and pre-hospitalization expenses recently. The premium/ contributions are shared between the employer and the employee. The premium paid by the employer is usually risk-related at the group level, but the premiums paid by the individuals are usually not risk-related. Note that the group insurance policy purchased as a micro insurance product is not categorized as employer based voluntary health insurance. It is part of community based voluntary health insurance. (Refer Page 173 - 174 **in SHA 2011** for further details).

6.1.4 Other primary coverage schemes (Individual voluntary health insurance)

Voluntary individual insurance provided by any of the 26 insurance companies (4 public and 22 private) in India that sell health insurance policies to individuals (households) falls under this category. The contribution or premium is risk related and the contract is between the insurance company and the individual/ household. (Refer Page 173 - 174 **in SHA 2011** for further details).

6.1.5 Community-based voluntary health insurance

Community health insurance schemes covering households, operated by non-government organizations fall within this category. They usually cover for inpatient care services. These schemes exist within localized communities, most often in rural areas: members make small payments to the scheme, often annually and after harvest time. There are 3 types of CHIs in the country. The first and the oldest type is the 'direct' model, where a hospital has initiated a health insurance product. The hospital is both the provider of care as well as the insurer. The second type is the 'mutual' model, where the NGO organizes and implements the insurance scheme and purchases care from various providers. Finally, the most common type is the 'linked' model, where the NGO collects premium from the community and purchases insurance from a formal insurance company and healthcare from providers. In India sometimes these schemes also use insurance companies for risk pooling and claims processing in the form of micro health insurance products as defined by IRDAI. Micro health insurance products are defined as micro-insurance plans insured by private and public insurance companies offering smaller premiums and a maximum coverage amounts up to Rs.30000 especially for the rural population or specific population groups. Local non-governmental organizations and self-help groups act as intermediaries to market the products and collect premiums. Some examples of CBHI schemes in India are ASHWINI, Vimo SEWA, Aarogya Suraksha Insurance, Uplift insurance schemes under Micro Insurance Academy (MIA) etc.[69] (Refer Page 175 in SHA 2011 for further details)

According to SHA 2011, all these schemes are classified and coded as given in **Table 6.1.** It is important to select the relevant code according to the scheme for mapping each expenditure line item. This will be explained in detail in the **Section 6.4** on mapping.

69 A list of community based health insurance schemes/ micro insurance schemes can be found at centre for health market innovations website and micro insurance initiative of the international labour organization website. As these are highly localized State specific information could be sought from literature search and expert opinion from the industry leaders.

Table 6.1: Identifying health insurance schemes to SHA 2011 framework classifications and codes

Health Insurance Schemes	SHA 2011 classification and code			
	Health financing Scheme (HF)	Revenue of financing scheme (FS)	Healthcare Providers (HP)	Healthcare Functions (HC)
Social Health Insurance Schemes	HF.1.2.1Social health insurance schemes	FS.1.1.1 Internal Transfers and Grants - Union Government FS.1.1.2 Internal Transfers and Grants - State Government FS.3.1Social insurance contributions from employees FS.3.2Social insurance contributions from employers	HP.1.1.1 General Hospitals -Government HP.1.1.2 General Hospitals - Private HP.1.3.1 Specialized hospitals (Other than mental health hospitals) - Government HP.1.3.2 Specialized hospitals (Other than mental health hospitals) -Private HP.3.1.1 Offices of general medical practitioners (Private) HP.3.4.9 All other ambulatory centers (Government) HP.7.2 Social health insurance agencies	HC.1.1.1 General Inpatient curative care HC.1.1.2 Specialized Inpatient curative care HC.1.3.1 General Outpatient curative care HC.1.3.3 Specialized Outpatient curative care HC.7.2 Administration of health financing HC.RI.1 Total pharmaceutical expenditure HC.RI.2 Traditional, Complementary and Alternative Medicines (TCAM)
Government Based Voluntary Insurance schemes	HF.2.1.1.2 Government-based voluntary insurance	FS.1.1.1 Internal Transfers and Grants - Union Government FS.1.1.2 Internal Transfers and Grants - State Government FS.5.1 Voluntary prepayment from individuals/households	HP.1.1.1 General Hospitals - Government HP.1.1.2 General Hospitals - Private HP.1.3.1 Specialized hospitals (Other than mental health hospitals) Government HP.1.3.2 Specialized hospitals (Other than mental health hospitals) Private HP.7.1 Government health administration agencies HP.7.3 Private health insurance administration agencies HP.7.9 Other health administration agencies	HC.1.1.1 General Inpatient curative care HC.1.1.2 Specialized Inpatient curative care HC.7.2 Administration of health financing HC.RI.1 Total pharmaceutical expenditure
Employer-based insurance (other than enterprises schemes)	HF.2.1.1.1 Employer-based insurance (other than enterprises schemes)	FS.5.1 Voluntary prepayment from individuals/households FS.5.2Voluntary prepayment from employers	HP.1.1.1 General Hospitals - Government HP.1.1.2 General Hospitals - Private HP.1.3.1 Specialized hospitals (Other than mental health hospitals) Government HP.1.3.2 Specialized hospitals (Other than mental health hospitals) Private HP.7.3 Private health insurance administration agencies	HC.1.1.1 General Inpatient curative care HC.1.1.2 Specialized Inpatient curative care HC.7.2 Administration of health financing HC.RI.1 Total pharmaceutical expenditure
Other primary coverage schemes (Individual voluntary health insurance)	HF.2.1.1.3 Other primary coverage schemes	FS.5.1 Voluntary prepayment from individuals/households	HP.1.1.1 General Hospitals - Government HP.1.1.2 General Hospitals - Private HP.1.3.1 Specialized hospitals (Other than mental health hospitals) Government HP.1.3.2 Specialized hospitals (Other than mental health hospitals) Private HP.7.3 Private health insurance administration agencies	HC.1.1.1 General Inpatient curative care HC.1.1.2 Specialized Inpatient curative care HC.7.2 Administration of health financing HC.RI.1 Total pharmaceutical expenditure

Health Insurance Schemes	SHA 2011 classification and code			
	Health financing Scheme (HF)	Revenue of financing scheme (FS)	Healthcare Providers (HP)	Healthcare Functions (HC)
Community Based Insurance schemes	HF.2.1.2.1 Community-based insurance	FS.5.1 Voluntary prepayment from individuals/households	HP.1.1.1 General Hospitals - Government HP.1.1.2 General Hospitals - Private HP.1.3.1 Specialized hospitals (Other than mental health hospitals) Government HP.1.3.2 Specialized hospitals (Other than mental health hospitals) Private HP.7.3 Private health insurance administration agencies HP.7.9 Other administration agencies – CBHI agencies	HC.1.1.1 General Inpatient curative care HC.1.1.2 Specialized Inpatient curative care HC.7.2 Administration of health financing HC.RI.1Total pharmaceutical expenditure

6.2 Data Sources for Health Insurance Expenditures

In this section, the data sources for health insurance expenditures for each of the health insurance schemes described above is presented. The most important data sources for health insurance expenditures are the union or state government budget books and data requested from the Controller General of Accounts (CGA), annual report of the Insurance Regulatory and Development Authority of India (IRDAI), annual report of the Insurance Information Bureau (IIB), annual reports of the government departments or the social health insurance agencies, annual reports of the government voluntary insurance schemes and non-government organizations implementing the CBHI insurance schemes. The data sources for health insurance schemes are identified in **Table 6.2**.

Table 6.2: Data sources for health insurance expenditures

Scheme	Data Source
Central Government Health Scheme (CGHS)	CGHS website (http://msotransparent.nic.in/cghsnew/index1.asp?linkid=4&langid=1) The section on frequently answered questions. The annual report of MoHFW-chapter on medical relief and supplies for CGHS utilization and expenditure related information. The non-tax revenue receipt of the union budget under the head social services – major head 0210 medical and public health for the details of household contribution towards CGHS. Details of CGHS reimbursements made to active employees are available in demand for grants of every department of the union ministry. These are recorded as 'medical treatment' and include reimbursements also made under the CS (MA) scheme. CS (MA) reimbursements should be excluded which are obtained from union budgets. The expenditure budget of DoHFW- MoHFW (demand for grant no.48) for Detailed expenditure line items on operating the CGHS dispensaries, reimbursements to empaneled health facilities for cashless treatments. The specific category of expenditures and the relevant budget codes, are: Setting up of CGHS Dispensaries (operations): 2210.01001.08, AYUSH Expansion in CGHS: 2210.01103.24, Medical Treatment of CGHS pensioners: 4210.01.103.04, CGHS Medical Reimbursement of employees from MoHFW:2071.01.01118.01.010006, CGHS administration – Directorate General of CGHS are available for the expenditure budget DoHFW, MoHFW. Medical Treatment Detail Head (06) under all Demand for grants of all Union Ministries should be captured specifically from the respective expenditure budgets. The details of medical treatment reimbursement are also available with Controller General of Accounts (CGA) available on special request for the purpose of NHA.
Employee State Insurance Scheme (ESIS)	ESIC website (http://esic.nic.in/index.php). ESIC annual report gives details of medical expenditures by state government and ESIC. Other source for state government contribution towards medical care is the demand for grants of state department of health and family welfare or the state department of Labour welfare. ESI features under major head 2210 and sub minor head 102 in these documents. It is necessary to use value of state contributions/ expenditures towards ESIS from any one data source – ESIC report or the state budget books. ESIC annual report's Financial Statement for the particular year is the source used, The detailed tables on total hospital beds, cost of care per hospital bed in each of the hospitals of ESIS across states, state wise expenditures on ESIS for the year 2013-14– for example this information is given in the Appendix-H, Appendix- III-1 in annual report for year 2013-14.

Scheme	Data Source
Ex-Servicemen Contributory Health Scheme (ECHS)	Information is available from ECHS website (http://www.echs.gov.in), ECHS handbook, and annual report of ministry of defence (2014-15). Details of expenditures available are in demand for grants.23 Defence services – army under major head 2076, demand no.28 capital outlay on defence services under major head 4076.
Contributory Health Services Scheme (CHSS)	Information on the scheme is available at the Department of Atomic Energy website with regular up to date office memorandums published. The expenditures related to the scheme are available from the Department of Atomic Energy Budget Book by the Union Government or the annual accounts at glance at the web link (http://www.dae.nic.in/writereaddata/aaag2015.pdf). The following links are useful to secure information on the scheme http://www.dae.nic.in/. http://nfc.gov.in/BARC%20chss_rules.pdf
Retired Employees' liberalized health scheme (RELHS)	The main source is Budget of Railways for specific year or on the webs site of the Railways. http://www.indianrailways.gov.in/railwayboard/ Currently the scheme is not disaggregated with a specific mention in the budget book and thus is part of the Railways Health Budget for Indian Railway Medical Services (IRMS) an aggregate spending. The Annual Report of the Ministry of Railways mentions the scheme and the information on the scheme can be thus procured from these.
Government Based Voluntary Health Insurance	The major data sources of any schemes under this is the union or state government budget book and expenditures are presented under the parent line ministry/ department heads. The scheme websites themselves and their annual reports are another good source of expenditures. Here data sources as an example for some schemes is presented below. Data sources for all schemes being identified under this category should be gathered by the NHA team before they embark on estimates.
Aarogyasri - Andhra Pradesh and Telangana	Information on the Scheme is available on the scheme website for both the respective states. Annual report is available on the website and is informative on expenditures on reimbursement. Another major source is the state budget book for the respective states, details of the scheme allocations are given in the budget of the department of health and family welfare under Medical and Public Health. Head 2210.01.789.09; 2210.01.796.09; 2210.01.001.09 and from head under department of planning for the share of fund received from Chief Minister's relief Fund (CMRF).
Vajpayee Aarogyashree – Karnataka	Information on the Scheme is available on the scheme website and the website of Suvarna Aarogya Suraksha Trust. Annual report is also available on the website and is informative on expenditures on reimbursement. Another major source is the state budget book for the state, details of the scheme allocations are given in the budget of the department of health and family welfare under Medical and Public Health. Head 2210.80.001.01; 2210.80.001.03; 2210.80.800.15. The scheme has a source of finance from the World Bank in 2013-14 through the state government featuring under the head KHSDRP-Health Financing (WORLD BANK): 2210-06-112-0-03.
Mukhyamantri Amrutam Yojana - Gujarat	Information on the Scheme is available on the scheme website. Another major source is the state budget book for the state, details of the scheme allocations are given in the budget of the department of health and family welfare under Medical and Public Health. Head 2211.103.6; 2211.796.5 (Aarogya Suraksha Yojana)
Comprehensive Health Insurance Scheme – Tamil Nadu	Information on the Scheme is available on the scheme website. Another major source is the state budget book for the state, details of the scheme allocations are given in the budget of the department of health and family welfare under Medical and Public Health. Head 2210.80.789.JA; 2210.80.789.JB; 2210.80.789.JC; 2210.80.796.JA; 2210.80.796.JB; 2210.80.800.JB; 2210.80.800.JJ; 2210.80.800.JL; 2075.800.HG
Rajeev Gandhi Jeevandayee Aarogya Yojana - Maharashtra	Information on the Scheme is available on the scheme website. Another major source is the state budget book for the state; details of the scheme allocations are given in the budget of the department of health and family welfare under Medical and Public Health. Head 2210.1.1.10; 2210.1.110.624; 2210.1.110.269; 2210.1.110.230; 2210.1.110.231; 2210.3.796.1-3; 2210.6.796.1-17
Rashtriya Swasthya Bima Yojana (RSBY) and similar schemes	Information on the Scheme is available on the scheme website (http://rsby.gov.in/). Another major source is the union and state budget books, details of the scheme allocations are given in the budget of Union Ministry of Labour and Employment and in the coming years in the budget of Union Ministry of Health and Family Welfare. Another source of Union Government allocations to the scheme is the annual report of Union Ministry of Labour and Employment. The state share is given in the state budget book under the line department implementing the scheme in the respective states.

Scheme	Data Source
Handloom Weavers Health Insurance Scheme	The source of information for this scheme is the annual report 2014-15 of union ministry of textiles available on their website (http://texmin.nic.in/annualrep/ar_14_15_englisHPdf; http://handlooms.nic.in/writereaddata/1237.pdf; http://www.nipFP.org.in/media/medialibrary/2013/08/insurance_report_final.pdf) The details on the expenditures can be sourced from the detailed demand for grants of the union ministry of textiles (2015-16) under the statement showing Grants-in-aid exceeding Rs.5 lakh (Recurring) or Rs.10 lakh (non-recurring sanctioned/released under Marketing & Export Promotion Scheme to private institutions/ organizations/ individuals during the year 2013-14 Grants/ Funds It is presented against the head CICI Lombard General Endurance Company Ltd for Enrolment of handloom weavers under Health Insurance Scheme.. The link for the same is (http://texmin.nic.in/budget/demand_for_grant/DDG_15_16_budget.pdf) Another data source is the information on the scheme's premium, coverage and claims paid out by the respective insurance company covering the scheme from the Insurance Regulatory Development Authority of India (IRDAI) or the Insurance Information Bureau..
Employer Based Health Insurance and Individual Voluntary Health Insurance (Other primary coverage schemes)	Information on voluntary health insurance can be sourced from the Insurance Regulatory Development Authority of India (IRDAI) annual reports and the annual report of the Insurance Information Bureau (IIB). These have detailed information on premium, coverage and claims paid out by insurance companies.
Community Based Health Insurance Schemes	Information on these schemes are sourced from their respective websites and also website for health market innovations and micro insurance products. SEWA and ASHWINI have the information on the website. Another important source of information is the IRDAI annual report that gives a list of micro insurance products in the country. The information available with Insurance Information Bureau on schemes below Rs.30000 maximum coverage can also be a source. However the community based insurance schemes data has to be clearly disaggregated from RSBY coverage data.

6.3 Boundaries for Health Insurance Expenditures

Each health insurance scheme is financed and organized differently incurring a variety of expenditures to deliver healthcare goods and services. According to boundary definitions of System of Health Accounts 2011 majority of health insurance expenditures are within this boundary except for those described below:

a. Social health insurance schemes operating their own health facilities and employing salaried workforce (e.g. central government health scheme, employee state insurance scheme) have expenditure line items involving building infrastructure (health facility buildings and information technology), purchase of equipment, medical education and research etc. These are treated as capital consumption and do not fall within the boundary for current health expenditures.

b. The employee state insurance scheme provides cash benefits in case of sickness, maternity, disablement, and death due to employment, injury to workers and dependents to cover for wage loss or other means.

c. Dividends/ interest or any capital gains or other revenues, insurance companies/ social health insurance agency makes on the total premium collected will not be taken into account as expenditure on health if this has not been consumed for health purpose during the current year. Such revenues will be excluded from all calculations for estimates on current expenditures in NHA. This also includes the reserves of the health insurance schemes.

d. Also when the claims paid out are lower than the premiums collected especially in the commercial insurance companies, only a part of the money left is adjusted as administrative expenses and the rest is excluded. The expenditure excluded is not considered as health insurance expenditure as it is not used for consumption of healthcare or any purpose related to it during that particular year.

6.4 Mapping and Classifications of Health Insurance Expenditures

To arrive at NHA estimates, the expenditure line items under each health Insurance scheme are mapped/ cross-walked to the classification codes. Table 6.3 shows expenditure line items specific for each category of health insurance scheme.

6.4.1 Expenditure line items under health insurance schemes

Expenditure line items related to health insurance expenditures fall into four categories and are found from the data sources indicated in section 6.2;

1. Reimbursements for inpatient care to either hospitals or the individuals/ households;
2. Expenditures on outpatient care, health promotion and prevention of disease;
3. Expenditures related to procurement of drugs
4. Administrative expenses for business operations of insurance companies or the government insurance institutions (office expenses, travel reimbursements, salaries/allowances to human resources, advertising, management of information systems etc.)

6.4.2 Methodology for mapping expenditure line items under health Insurance

- Expenditure line items related to health insurance expenditures should not be mapped elsewhere in other data sources. For example CGHS, ECHS, CHSS, ESIS, Government based voluntary health insurance related expenditures all appear under expenditure budgets of respective departments. These should not be mapped there.
- Expenditure line items under each category of health insurance scheme presented here are indicative only. With changes in presentation of demand for grants /budget books or any other data source or due to the dynamic nature of the schemes themselves there can be changes in the way expenditures are presented. Some times more line items might be added to this list.
- Any change in expenditure line items should accompany re-considering the classification and codes mapped against them.
- Addition or changing of the insurance scheme or the respective expenditure line items should always obey the definitions as stated in these guidelines for insurance scheme categories and also lie within the purview of SHA 2011.

The mapping for each expenditure line item is presented in **Table 6.3**. Every line item is indicated with a code in column 1[70]; description of expenditure line item is in column 2, as given in the budget book or any other data source. All expenditure line item related to capital expenditure or capital account (HK) are excluded and do not feature in the table; expenditure value is in column 3; SHA 2011 classification codes for Revenue of financing schemes (FS), Health financing schemes (HF), Healthcare Providers (HP) and Healthcare functions (HC) are in column 4 - 7.

70 This code corresponds to the line item and is for indication only. It is usually any alphabet followed by 3 digits starting with 001. The NHA team can give any such code as this is useful during estimation using HAPT (Health Accounts Production Tool).

Table 6.3: Mapping health insurance expenditure line items to SHA 2011 framework classification codes

Code	Expenditure Line item	Expenditure	FS	HF	HP	HC
C001	Setting up of CGHS Dispensaries		FS.1.1.1, FS.3.1	HF.1.2.1	HP.3.4.9	HC.1.3.1, HC.RI.1[71]
C002	AYUSH Expansion in CGHS		FS.1.1.1, FS.3.1	HF.1.2.1	HP.3.4.9	HC.1.3.1, HC.RI.2[72]
C003	Medical Treatment of CGHS pensioners		FS.1.1.1, FS.3.1	HF.1.2.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2	HC.1.1.1, HC.1.1.2, HC.RI.1
C004	CGHS Medical Reimbursement of employees of all Union Ministries/ Departments		FS.1.1.1, FS.3.1	HF.1.2.1	HP.10[73]	HC.9[74]
C005	Directorate General of CGHS		FS.1.1.1, FS.3.1	HF.1.2.1	HP.7.2	HC.7.2
E001	ESIS Medical care		FS.1.1.2, FS.3.1, FS.3.2	HF.1.2.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.1.1, HP.3.4.9,	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.RI.1
E002	ESIS Administration		FS.1.1.2, FS.3.1, FS.3.2	HF.1.2.1	HP.7.2	HC.7.2
M001	ECHS Medical care		FS.1.1.1, FS.3.1	HF.1.2.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.RI.1
M003	ECHS Administration		FS.1.1.1, FS.3.1	HF.1.2.1	HP.7.2	HC.7.2
S001	CHSS Medical care		FS.1.1.1, FS.3.1	HF.1.2.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1/ HP.7.2	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1
Z001	RELHS Medical care		FS.1.1.1, FS.3.1	HF.1.2.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9, HP.7.1	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.7.2, HC.RI.1
A001	Aarogyasri Scheme, Andhra Pradesh – Expenditures		FS.1.1.2	HF.2.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.9[75]	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1
K001	Vajpayee Aarogyashree Karnataka – Expenditures		FS.1.1.2, FS.2.2[76]	HF.2.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.9	HC.1.1.2, HP.7.2, HC.RI.1

71 HC.RI.1 indicates total pharmaceutical expenditure and should be marked against any expenditure line item that is inclusive of expenditures on pharmaceuticals.

72 HC.RI.2 indicates that the expenditure under the line item is related to Traditional Alternative Complementary Medicine (TCAM). This code is useful to sum up all the expenditures that belong to TCAM from various data sources in this section and elsewhere. During allocation kindly note that expenditures should not be exclusively allocated this code, these can be part of any other code but just do not double count them.

73 The expenditure line item CGHS Medical Reimbursement of employees from all Union ministries is classified as HP.10 (Healthcare providers not elsewhere classified) as in the current context, medical bills are reimbursed to the employee and there is no data base that captures details of the healthcare provider that employee made the payment to, making it difficult to classify. As and when such information becomes available, it is advised this be classified as HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 and HP.3.4.9 or any relevant code under HP.category. Respective allocation formulae are to be developed for the same.

74 The expenditure line item CGHS Medical Reimbursement of employees from other ministries is classified as HC.9 for the same reason above as no details of disease or treatment / surgical procedure for which the payment was made is available making it difficult to classify further. As and when such information becomes available, it is advised this be classified as HC.1.1.1, HC.1.1.2 and HC.1.3.1. Respective allocation formulae for the same are to be developed.

75 A part of expenditure under the government based voluntary health insurance schemes either Aarogyasri or Vajpayee Aarogyashree or Rajeev Gandhi Jeevandayee Aarogya Yojana is classified as HP.7.9 (other administration agencies) as their implementation is through Trusts or societies or any such special purpose vehicles created by the government and the government pays for their administrative expenses and the same are given in the expenditure budgets of the line department. Same rule has to be followed when any such schemes are being classified.

76 The scheme has a source of finance from the World Bank in 2013-14 through the state government featuring under the head KHSDRP-Health Financing (WORLD BANK): 2210-06-112-0-03.

Code	Expenditure Line item	Expenditure	FS	HF	HP	HC
G001	Mukhyamantri Amrutam Yojana Gujarat – Expenditures		FS.1.1.2	HF.2.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1[77],	HC.1.1.2, HP.7.2, HC.RI.1
T001	Comprehensive Health Insurance Scheme Tamil Nadu – Expenditures		FS.1.1.2	HF.2.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1, HP.7.3[78]	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1
H001	Rajeev Gandhi Jeevandayee Aarogya Yojana Maharashtra – Expenditures		FS.1.1.2	HF.2.1.1.2	HP.1.1.1, HP.1.1.2 HP.1.3.1, HP.1.3.2, HP.7.9, HP.7.3	HC.1.1.1, HC.1.1.2, HP.7.2, HC.RI.1
R001	RSBY – Expenditures		FS.1.1.1, FS.1.1.2, FS.5.1	HF.2.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1, HP.7.3	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1
W001	Handloom Weavers Health Insurance Scheme – Expenditures		FS.1.1.1, FS.5.1	HF.2.1.1.2	HP.1.1.1, HP.3.1.1, HP.7.1, HP.7.3	HC.1.1.1, HC.1.3.1, HC.7.2, HC.RI.1
I001	Individual Voluntary Health Insurance – Premiums or Reimbursements		FS.5.1	HF.2.1.1.3	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.3	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1
G001	Employer based voluntary health Insurance – Premiums or Reimbursements		FS.5.1	HF.2.1.1.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.3	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1
B001	Community based health insurance expenditures		FS.5.1	HF.2.1.2.1	HP.1.1.1, HP.1.1.2, HP.7.3, HP.7.9[79]	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1

6.5 Development of Allocation Keys for Some Expenditure Line Items

Expenditure line items when mapped against the SHA 2011 classifications might have multiple revenues of financing schemes, healthcare providers and healthcare functions requiring a given line item's expenditures to be apportioned or split among the related classification codes. Incase of health insurance expenditures this is observed at HP.and HC.level. Allocation keys are required to arrive at proportions of these splits. Such splits under any of the classification can be arrived from the existing data sources or after considering literature search on the related subject or through expert opinion. In case of the splits are not available, a research study conducted on a sample of these providers, might be beneficial.

Administrative expenses for voluntary health insurance schemes are calculated as (service fee) = Total premium + Supplements - Claims paid out. IRDAI in its annual report provides details regarding health insurance claims paid out. In the above formula, the supplements will remain as '0' for insurance companies as it is difficult to arrive at the company's internal mechanisms to bridge the deficits that occur when claims paid out are more than the premiums collected. These are usually adjustments made from various portfolios within the company during the same year or over a period of years. The above formula works well until the total premium is higher than the claims paid out and the difference between these is well within a reasonable limit and not very high, which has been the case so far. However we expect two instances where this formula might not work. (1) In case the difference between premium and claims is very high, let's say claims paid is only 20%. It is not

77 A part of expenditure under the government based voluntary health insurance schemes either Mukhyamantri Amrutam Yojana Gujarat or Comprehensive Health Insurance Scheme Tamil Nadu or RSBY is classified as HP.7.1 (Government health administration agencies) as these are partly implemented by the line departments themselves that select the insurance company and monitor them. The government pays the administrative expenses for the departments and the same are given in the expenditure budgets of the line department. Same rule has to be followed when any such schemes are being classified.

78 A part of the expenditure under the government based voluntary health insurance schemes either Rajeev Gandhi Jeevandayee Aarogya Yojana Maharashtra or Comprehensive Health Insurance Scheme Tamil Nadu or RSBY are classified as HP.7.3 (Private health insurance administration agencies) as these are implemented directly through the private insurance companies themselves.

79 A part of the expenditure under the community based health insurance is classified as HP.7.3 ((Private health insurance administration agencies) and HP.7.9 (other administration agencies). As described in the related CBHI definitions, the scheme can be implemented by an NGO or not for profit organization which corresponds to the code HP.7.9. However it is also common that in India the NGO or Not for profit organization can use an insurance company to insure the population which then corresponds to also allocate the expenditure to code HP.7.3 as we would be using both the codes for the same scheme.

realistic to consider the rest 80% of premium as administrative expenses. (2) In case the claims paid are higher than the total premium, let's say claims paid are 120%. It is not realistic to assume there is '0' administrative expenditure. In such instances, the administrative expenses should be capped at a value equal to the cap on administrative expenses as provided by IRDAI in 17E (Commission and management expenses of insurance companies) of the Insurance Act. Another way is to cap it to administrative expenses of ESIS in a specific year. For 2013-14 this is 15% of premium. We believe it is safe to assume this, as the administration of ESIS is most robust in the country and the administrative expenses of ESIS can be safely assumed as on the highest order (as for most government agencies). If the value using above formula stays within this cap, we consider the exact value. If the value using above formula is beyond the cap, we will treat the administrative expense as the cap only (here it will be 15%).

For the health insurance expenditures, literature search of the available information is usually sufficient as the schemes largely cover only curative services, with well-defined payment structures. However one has to note that the allocation keys developed have to be revisited every year as the proportions of these expenditures might change year on year. However the methodology of arriving at allocation keys will remain the same. **Table 6.4** shows the allocation keys for health insurance scheme expenditure line items.

Table 6.4: Allocation keys for health insurance expenditures

Code	Expenditure Line item	FS	HP	HC	Allocation Keys/ Formulae
C001	Setting up of CGHS Dispensaries	FS.1.1.1, FS.3.1	HP.3.4.9	HC.1.3.1 HC.RI.1[80]	The aggregate expenditure under the scheme is divided into FS.1.1.1, FS.3.1 in the same proportion as the ratio of contribution by the government and contribution by the employees.
C002	AYUSH Expansion in CGHS	FS.1.1.1, FS.3.1	HP.3.4.9	HC.1.3.1, HC.RI.2[81]	The aggregate expenditure under the scheme is divided FS.1.1.1, FS.3.1 in the same proportion as the ratio of contribution by the government and contribution by the employees.
C003	Medical Treatment of CGHS pensioners	FS.1.1.1, FS.3.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2	HC.1.1.1, HC.1.1.2, HC.RI.1	The aggregate expenditure under the scheme is divided FS.1.1.1, FS.3.1 in the same proportion as the ratio of contribution by the government and contribution by the employees. The aggregate expenditure under the scheme is divided in to HP.1.1.1, HP.1.1.2, HP.1.3.1, and HP.1.3.2 in the ratio of reimbursements paid to various types of empanelled private and public hospitals under CGHS. The expenditure under each of the HP.codes is divided into HC.1.1.1 and HC.1.1.2 as the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of HC.1.1.1 and HC.1.1.2 is indicated with HC.RI.1.
C004	CGHS Medical Reimbursement of employees from all Union Ministries/ Departments	FS.1.1.1, FS.3.1	HP.10[82]	HC.9	The aggregate expenditure under the scheme is divided FS.1.1.1, FS.3.1 in the same proportion as the ratio of contribution by the government and contribution by the employees.
C005	Directorate General of CGHS	FS.1.1.1, FS.3.1	HP.7.2	HC.7.2	The aggregate expenditure under the scheme is divided FS.1.1.1, FS.3.1 in the same proportion as the ratio of contribution by the government and contribution by the employees.

80 HC.RI.1 indicates that the expenditure under the line item is related to Total Pharmaceutical Expenditures (TPE). This code is useful to sum up all the expenditures that belong to pharmaceutical expenditures from various data sources in this section and elsewhere. During allocation kindly note that expenditures need not be exclusively allocated under this code, these expenditures can be part of any other code but just do not double count them.

81 HC.RI.2 indicates that the expenditure under the line item is related to Traditional Alternative Complementary Medicine (TCAM). This code is useful to sum up all the expenditures that belong to TCAM from various data sources in this section and elsewhere. During allocation kindly note that expenditures need not be exclusively allocated under this code, these expenditures can be part of any other code but just do not double count them.

82 The expenditure line item CGHS Medical Reimbursement of employees from all Union ministries is classified as HP.10 (Healthcare providers not elsewhere classified) as in the current context, medical bills are reimbursed to the employee and there is no data base that captures details of the healthcare provider that employee made the payment to, making it difficult to classify. As and when such information becomes available, it is advised this be classified as HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 and HP.3.4.9 or any relevant code under HP.category. Respective allocation formulae are to be developed for the same.

Code	Expenditure Line item	FS	HP	HC	Allocation Keys/ Formulae
E001	ESIS Medical care	FS.1.1.2, FS.3.1, FS.3.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9, HP.3.1.1	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.6.4, HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.2, FS.3.1, and FS.3.2 in the proportion of contribution by the state government, employer and employee. The aggregate expenditure under the scheme is divided in to HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9, HP.3.1.1 in the proportion of expenditures in ESIS hospitals, empanelled private hospitals, empanelled public and private specialized hospitals, ESI dispensaries and Insurance Medical Practitioners (doctors contracted by ESIC to deliver outpatient care) The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2 HC.1.3.1, HC.6.4, and HC.RI.1 as the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
E002	Administration – ESIS	FS.1.1.2, FS.3.1, FS.3.2	HP.7.2	HC.7.2	The aggregate expenditure under the scheme is divided into FS.1.1.2, FS.3.1, and FS.3.2 in the proportion of contribution by the state government, employer and employee.
M001	ECHS Medical care	FS.1.1.1, FS.3.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.1 and FS.3.1, in the proportion of contribution by the Union government and employee. The aggregate expenditure under the scheme is divided in to HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9, in the proportion of expenditures in each of the providers. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2 HC.1.3.1 and HC.RI.1 as the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC components is indicated with HC.RI.1.
M002	ECHS Administration	FS.1.1.1, FS.3.1	HP.7.2	HC.7.2	The aggregate expenditure under the scheme is divided into FS.1.1.1 and FS.3.1, in the proportion of contribution by the Union government and employee.
S001	CHSS Medical care	FS.1.1.1, FS.3.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1/ HP.7.2	HC.1.1.1, HC.1.1.2, HC.7.2, HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.1 and FS.3.1, in the proportion of contribution by the Union government and employee. The aggregate expenditure under the scheme is divided in to HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1/HP.7.2 in the proportion of expenditures in each of the providers. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2. andHC.RI.1 as the proportion of expenditure under each of the component at that provider. HP.7.1/HP.7.2 will be allocated to HC.7.2. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
Z001	RELHS Medical care	FS.1.1.1, FS.3.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9, HP.7.1	HC.1.1.1, HC.1.1.2, HC.1.3.1, HC.7.2, HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.1 and FS.3.1, in the proportion of contribution by the Union government and employee. The aggregate expenditure under the scheme is divided in to HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.3.4.9, HP.3.7.1 in the proportion of expenditures in each of the providers. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2 HC.1.3.1 and HC.RI.1 as the proportion of expenditure under each of the component at that provider. HP.7.1 will be allocated to HC.7.2. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.

Code	Expenditure Line item	FS	HP	HC	Allocation Keys/ Formulae
A001	Aarogyasri Scheme, Andhra Pradesh - Expenditures	FS.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.9	HC.1.1.1, HC.1.1.2, HP.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.9, in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
K001	Vajpayee Aarogyashree Karnataka – Expenditures	FS.1.1.2, FS.2.2[83]	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.98	HC.1.1.2, HP.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.2 and FS.2.2 according to the proportion of financing each from each source The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.9, in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
G001	Mukhyamantri Amrutam Yojana Gujarat – Expenditures	FS.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.1	HC.1.1.2, HP.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1, in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
T001	Comprehensive Health Insurance Scheme Tamil Nadu – Expenditures	FS.1.1.2	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.1, HP.7.3	HC.1.1.1, HC.1.1.2, HP.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.1 and HP.7.3 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
H001	Rajeev Gandhi Jeevandayee Aarogya Yojana Maharashtra – Expenditures	FS.1.1.2	HP.1.1.1, HP.1.1.2 HP.1.3.1, HP.1.3.2 HP.7.9, HP.7.3	HC.1.1.1, HC.1.1.2, HP.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2, HP.7.3 and HP.7.9 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.

83 The scheme has a source of finance from the World Bank in 2013-14 through the state government featuring under the head KHSDRP-Health Financing(WORLD BANK): 2210-06-112-0-03.

Code	Expenditure Line item	FS	HP	HC	Allocation Keys/ Formulae
R001	RSBY – Expenditures	FS.1.1.1, FS.1.1.2, FS.5.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.1, HP.7.3	HC.1.1.1, HC.1.1.2, HC.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.1, FS.1.1.2, FS.5.1 in proportion of contributions from the Union Government, State Government and the household (Rs.30 paid in the form of registration fee) The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.7.1, HP.7.3 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
W001	Handloom Weavers Health Insurance Scheme – Expenditures	FS.1.1.1, FS.5.1	HP.1.1.1, HP.3.1.1, HP.7.1, HP.7.3	HC.1.1.1, HC.1.3.1, HC.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into FS.1.1.1 and FS.5.1 in proportion of contributions from the Union Government and the household (paid in the form of premium) The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.3.1.1, HP.7.1, HP.7.3 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.3.1, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
I001	Individual Voluntary Health Insurance – Premiums or Reimbursements	FS.5.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.3	HC.1.1.1, HC.1.1.2, HC.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, and HP.7.3 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, HP.1.3.1, HP.1.3.2 and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
G001	Employer based voluntary health Insurance – Premiums or Reimbursements	FS.5.1	HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 HP.7.3	HC.1.1.1, HC.1.1.2, HC.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.1.3.1, HP.1.3.2 and HP.7.3 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.
B001	Community based health insurance – Expenditures	FS.5.1	HP.1.1.1, HP.1.1.2, HP.7.3, HP.7.9	HC.1.1.1, HC.1.1.2, HC.7.2 HC.RI.1	The aggregate expenditure under the scheme is divided into HP.1.1.1, HP.1.1.2, HP.7.3 and HP.7.9 in the proportion the expenditure is recorded/ reported in the data source under each of these providers. The division between public and private providers if not provided in the data source, it can be arrived from evaluation studies conducted on the scheme. The expenditure under each of the HP.codes is divided into HC.1.1.1, HC.1.1.2, and HP.7.2 in the proportion of expenditure under each of the component at that provider. The total expenditure on pharmaceuticals, already part of the HC.components is indicated with HC.RI.1.

CHAPTER 7

Health Expenditure by External Agencies

This chapter highlights the methodology to be adopted to estimate the external assistance received by the country from international agencies/governments for health sector development.

External assistance for health has an important role in the country's health budget as some of the critical areas that require strengthening which in turn contribute to the overall well-being of the disadvantaged sections are being financed through these funds. External Assistance for health is received in the form of bilateral assistance and multilateral assistance from foreign national governments and from international funding agencies and foreign non-governmental organisations. These are mainly in the form of loans, grants and in-kind (commodities and services) assistance [84].

The funding from international organisations can be either on-budget or off-budget. On- budget support constitutes transfers from bilateral and multilateral agencies that are provided through the government's budget wherein the government allocates the money received to specific areas earmarked for health. Off-budget support is the funding that is reflected in the country's balance of payments and not in the government's budget. These are channelized through Non-Governmental Organizations for projects implemented directly by international donors or through contracting directly with providers, by-passing the government's public expenditure management system[85].

External assistance for health accounted as transfers through the Ministry of Health and Family Welfare for various health sector priorities of the Central Government and State governments; The State governments direct receipts; and the NGOs receipts of total foreign contributions[86]. Most of the funds received from external sources are channelized towards control of communicable diseases, construction and running of hospitals and dispensaries, maternal and child health and family welfare programmes, rehabilitative and long term nursing care, and supply of medicine, material aids, visual aids and family planning aids.

7.1 Boundaries for External Assistance

External assistance is only included for those activities which fall under the boundaries of healthcare as defined in Chapter 2. External assistance in form of loans are generally taken to cover the state budget expenditure that is not balanced by domestic revenues and are not included as source of revenues from external agencies. Health sector specific loans are incurred for investments in the health sector. By definition, loans are changes

84 Department of Economic Affairs. 2001. External Assistance Manual. Ministry of Finance, Government of India

85 "Gottret, Pablo; Schieber, George. 2006. Health Financing Revisited: A Practitioner's Guide. Chapter 4: Ex-ternal Assistance for Health. Washington, DC: World Bank.

86 National Health Accounts Cell. 2009. National Health accounts India (2004-05). Ministry of Health and Family Welfare, Government of India, New Delhi.

in financial assets or liabilities (loans do not constitute a part of revenues)[87]. The SHA 2011 Manual does not address general public finance issues, such as, debt liability or debt repayment. Debt relief and debt cancellation are also not considered for this study. Hence, loans and debt liability have been kept out of boundary of NHA.

7.2 Data Sources for External Assistance to Health Sector

7.2.1 Government data sources:

i. Detailed Demand for Grants (Health Budget documents) of the Ministry of Health and Family Welfare and State Departments of Health and Family Welfare is a major source to understand the channel of assistance and track the flow of external funds towards different healthcare functions

ii. The utilization of external assistance received for health sector development from various bilateral and multilateral agencies in the form of grants and commodity assistance can be tracked from the information available on utilization of grants with the Office of the Controller of Aid Accounts and Audit Division (CAAA), Ministry of Finance, Government of India.

iii. The details of grants given to NGOs for specific health interventions can be obtained from the Foreign Contributions Regulatory Authority (FCRA) Division of the Ministry of Home Affairs, Government of India.

7.2.2 Creditor Reporting System (CRS) and Development Assistance Committee (DAC) Database:

The OECD-DAC maintains two databases on aid flows: (i) the DAC annual aggregates database, which provides summaries of the total volume of flows from different donor countries and institutions to the recipient country, and (ii) the CRS portal (https://stats.oecd.org/Index.aspx?DataSetCode=CRS1), provides details of grants given to the NGOs and Civil Society in a recipient country. This database consists of project type data with disaggregates at the activity-level and also data on expert and technical assistance provided to the NGOs by the donor countries/agencies.

These two databases track the following types of resource flows[88]:

A. Official Development Assistance (ODA), defined as "flows of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective" from its 24 members (Austria, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, the United Kingdom, the United States, and the European Commission). The CRS of late includes some private ODA, such as those funded by BMGF and GFATM, as well as assistance from the United Arab Emirates, Kuwait, the Czech Republic and Iceland.

B. Official Development Finance (ODF), which includes grants and loans made by multilateral agencies.

7.2.3 Survey of external agencies

This survey is done when the available information on external resources for health sector obtained from the above mentioned data sources are found to be inadequate and inconsistent. It would also serve as an important input to validate and triangulate the data obtained from all the sources detailed above. This survey involves identifying and listing all donor agencies – bilateral, multilateral and international agencies that transfer funds for health sector development in India; obtain details of assistance provided by them in the form of grants and also the distribution of funds by priority for various health related activities.

87 A System of Health Accounts, OECD Publishing. OECD, Eurostat, WHO.2011

88 Institute of Health Metrics and Evaluation. 2015. Financing Global Health 2014: Shifts in Funding as the MDG Era Closes. Seattle. Washington D.C.

The Health Account Production Tool (HAPT), provides a convenient way to carry out this survey. Once list of all donors is input into the HAPT tool, the Excel format survey files are automatically created for each of the donor and the required data is adequately captured.

i. State Health Accounts specific database: The above mentioned data sources on external assistance holds good while developing the Health Accounts for the country as a whole. The states have to adopt a different approach to track the flow of funds from the international donor agencies while developing their State Health Accounts. Apart from tracking the fund flows available from the Demand for Grants of the State Department of Health and Family Welfare, it would be appropriate to undertake a NGO survey. The objective of carrying out this survey would be to track all NGOs in the state that focuses its work in the health domain; and obtain from them the details of foreign contributions/aid received for various health sector priorities they undertake. The utilisation of foreign contributions received by NGOs for health can be obtained directly from the respective NGO offices from their Annual Reports, Audited Financial Statements and from their websites if details of funds are available. This survey would enable better to track the program expenses at a disaggregate level, a greater coverage and understanding of health focus areas of donor organisations. If the list of NGOs is exhaustive, data collection would be time consuming and it also depends on the resources available with the state to carry out the survey. In such cases, it would be relevant to arrive at a representative sample of the NGOs and then undertake the survey.

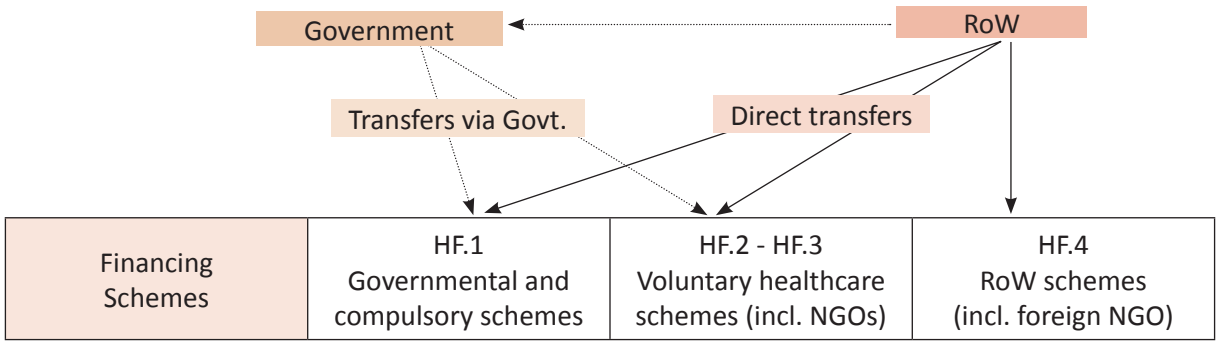
7.2.5 Data triangulation

From the above discussion on data sources, it is evident that the CRS data base provides the aggregate disbursements and activity level data. The utilisation of funds tends to be more appropriate than disbursements for the purpose of arriving at the estimates for health accounts. Therefore, the data obtained from the Office of the Controller of Aid Accounts and Audit Division, Ministry of Finance and from the FCRA Division of the Ministry of Home Affairs is considered as the most authentic sources for utilisation of external funds for various healthcare services. Besides this, the external resources directed through the Central and State governments towards specific items of health services as captured in their Demand for Grants is also taken into account. If there are any items that are not captured by the above mentioned data sources, the missing information can be filled using the details available from the CRS data base. The CRS data base can also be used to triangulate the data obtained from various sources.

7.3 Classification, Methodology and Estimates

The flow of funds from external agencies (also known as Rest of the World) and the transfer of resources from government revenues to the various financing schemes are depicted in **Figure 7.1.**

Fig.7.1: Transfers from government revenues to various financing schemes



ROW – Rest of the World

As understood from SHA 2011, the main ways revenues from foreign entities directly (via transfers) received by health financing schemes may be transacted are:

- Direct foreign financial revenues earmarked for health - These revenues are usually grants by international agencies or foreign governments, or voluntary transfers (donations) by foreign NGOs or individuals that contribute directly to the funding of domestic health financing schemes. There are two sub-categories of foreign direct revenues – (i) Financial transfers or foreign aid in kind (goods or services) (ii) Bilateral, multilateral or other transfers. The detailed sub-categories of foreign revenues include: direct bilateral financial transfers, direct multilateral financial transfers, other direct foreign financial transfers; direct bilateral aid in goods, direct multilateral aid in goods, other direct foreign aid in goods; and direct foreign aid in services (including Technical Assistance).
- Direct foreign aid in kind (healthcare goods and services).

7.3.1 Classification of external assistance to health sector

The classification of Financing Schemes, Revenues of the Financing Schemes, Healthcare Provision and Healthcare Functions for components that are funded by international organisations/governments would be done according to the Codes described in the SHA 2011 Guideline. If the external assistance is channelled through government, these flows would be recorded under FS.2.1 in case of Central Government and FS.2.2 for State Government. All direct foreign contributions received by NGOs/Civil Society under various schemes would be classified as FS.7.1.4. If the nature of contributions is known, for instance if the contributions can be bifurcated into aid in kind and aid in goods, then these would be classified as FS.7.2.2 and FS.7.2.1 respectively.

From the data on utilisation of external grants received from CAAA and the data available from the CRS database, it is evident that the details of external assistance for health to a recipient country can be tracked by the channel of assistance and the type of assistance. The funding priorities of the donor agencies towards various health and health related items can also be understood from the available data sources on external assistance. The details of external assistance received for each items of care needs to be tracked for its source in order to identify whether these are from bilateral, multilateral and international donor organisations. The items would then be collated, classified and coded based on the type of providers and various healthcare functions as followed in the SHA 2011 Guideline.

From the NHA 2004-05 and from the data on utilisation of external grants, it is evident that the amount which flows into the country from different channels for specific health services is extremely low. Yet this component becomes significant when we look at the impact of these funds on the intended beneficiaries. For the purpose of NHA for the country as a whole, the external assistance received can be grouped under three categories – bilateral, multilateral and contributions from donor organisations.

To give an understanding of the funding priorities of the external agencies, the following table presented below captures the details of health and related items available from the utilisation of grants data from CAAA and NHM budget documents with their respective codes.

Table 7.1: External assistance to health and health related areas with codes and classification

Source	Channel of Assistance	Health activities funded	FS	HF	HP	HC
Government of Japan	Bilateral	Institute of Child Health & Hospital for Children	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HP.1.3.1	HC.1.1.2
Government of UK	Bilateral	Health Sector Reform / Support / Strengthening Programme	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HP.7.1	HC.7.1.nec
European Union	Multilateral	NRHM/Reproductive Child Health II	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HP.3.4.1	HC.6.4
GLF Global Fund	Multilateral	Intensified Malaria Control Project, Phase II (IMCP-II)	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HC.6	HC.6.5.nec

Source	Channel of Assistance	Health activities funded	FS	HF	HP	HC
USAID	Bilateral	AIDS Prevention and Control Project	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HC.6	HC.6.5.nec
UNDP	Multilateral	Support to the National Efforts for Mainstreaming of HIV	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HP.7.1	HC.7.1.nec
World Bank	Multilateral	Reproductive and Child Health program	FS.2.2	HF.1.1.1.1/ HF.1.1.2.1	HP.3.4.1	HC.6.4

Source: Utilisation of Grants, CAAA and NHM Budget Document, MOHFW

Note: These grants although come from a foreign origin are routed through the government – either the Central government or through the State government.

The grants from international donor agencies like the Bill and Melinda Gates Foundation, Ford Foundation, Population Services International, Action Aid, Leprosy Mission International and many more agencies are significant to the health status development of selected target groups and specific health purpose in the population. These donor agencies directly support NGOs across states through (i) financial transfers, (ii) aid in kind and (iii) aid in goods. The NGO survey that the states need to undertake when developing state specific health accounts will provide disaggregate details of the funds utilised under all these three categories mentioned above. It would also highlight the benefits / outcomes of the grants for various health and health related services.

The following table presented below gives an understanding of the various project type interventions made by the international donor agencies to the NGOs and Civil Societies and the classification of the activities in accordance to the SHA 2011.

Table 7.2: Mapping expenditure line items by international donor agencies for health and related activities to SHA 2011 classification codes

Budget line code	Health Sector Grants	Current Consumption (CC) or Capital Consumption (HK)	FS	HF	HP	HC
EX001	Health Policy & Admin. Management	CC	FS.7.1.4	HF.2.2.2	HP.7.9	HC.7.1.nec
EX002	Medical Education/Training	HK				
EX003	Medical Services	CC	FS.7.1.4	HF.2.2.2	HP.1.1.2	HC.1.1.1, HC.1.3.1
EX004	Basic Healthcare	CC	FS.7.1.4	HF.2.2.2	HP.3.4.9	HC.1.3.1
EX005	Basic Health Infrastructure	HK				
EX006	Basic Nutrition	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.4
EX007	Infectious Disease Control	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec
EX008	Health Education	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.1.nec
EX009	Malaria Control	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec
EX010	Tuberculosis Control	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec
EX011	Health Personnel Development	HK				
EX012	Population policy and admin management	CC	FS.7.1.4	HF.2.2.2	HP.7.1	HC.7.1.nec
EX013	Reproductive Healthcare	CC	FS.7.1.4	HF.2.2.2	HP.3.4.1	HC.6.4
EX014	Family Planning	CC	FS.7.1.4	HF.2.2.2	HP.3.4.1	HC.6.4
EX015	STD Control including HIV/AIDS	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec
EX016	Basic Health Infrastructure	HK				
EX017	Basic Healthcare	CC	FS.7.1.4	HF.2.2.2	HP.3.4.9	HC.1.3.1
EX018	Basic Nutrition	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.4
EX019	Infectious Disease Control	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec

Budget line code	Health Sector Grants	Current Consumption (CC) or Capital Consumption (HK)	FS	HF	HP	HC
EX020	Health Education	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.1.nec
EX021	Tuberculosis Control	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec
EX022	Health Policy & Admin. Management	CC	FS.7.1.4	HF.2.2.2	HP.7.1	HC.7.1.nec
EX023	Medical Education/Training	HK				
EX024	Medical Services	CC	FS.7.1.4	HF.2.2.2	HP.1.1.2	HC.1.1.1, HC.1.3.1
EX025	Reproductive Healthcare	CC	FS.7.1.4	HF.2.2.2	HP.3.4.1	HC.6.4
EX026	STD Control including HIV/AIDS	CC	FS.7.1.4	HF.2.2.2	HP.6	HC.6.5.nec
EX027	Health, General -Experts & Other Technical Assistance	CC	FS.7.1.4	HF.2.2.2	HP.1.1.2	HC.1.1.1
EX028	Basic Health - Experts & Other Technical Assistance	CC	FS.7.1.4	HF.2.2.2	HP.3.4.9	HC.1.3.1
EX029	Population Policy/Program and Reproductive Health - Experts & Other Technical Assistance	CC	FS.7.1.4	HF.2.2.2	HP.3.4.1	HC.6.4

CHAPTER 8

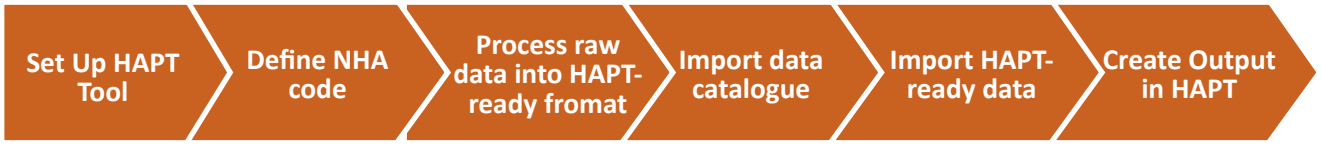
Presentation of Results, Tables & Basic Indicators using Health Accounts Production Tool (HAPT)

Invaluable information on Indian Health System is available under various domains and resources. However, it becomes useful in real-sense for policy makers once it is structured and presented in a standardized way. Presenting key results to technical team and key stakeholders and using these results to shape key messages & writing the report to disseminate the messages is one of the key outputs of NHA production. This chapter encapsulates the way data is structured, processed and presented after what has been already explained in the preceding chapters. This chapter helps user in understanding the process for data compilation and subsequent uploading into HAPT and creating outputs, keeping in mind the Indian health system. HAPT transforms the "raw data" into a meaningful tabulation after mapping each data point into respective element of "Axes of Healthcare Expenditure" (refer chapter 1).

8.1 Organizing Data for National Health Accounts Outputs

HAPT is a globally accepted tool that helps in creating National Health Accounts (NHA) with well-defined procedure and methodology that helps in structuring the data and providing relevant output. A very elaborate documentation exists on HAPT[89]. Brief steps outlined in Figure 8.1 are explained in the following sections.

Figure 8.1: Process for creating national health accounts using HAPT



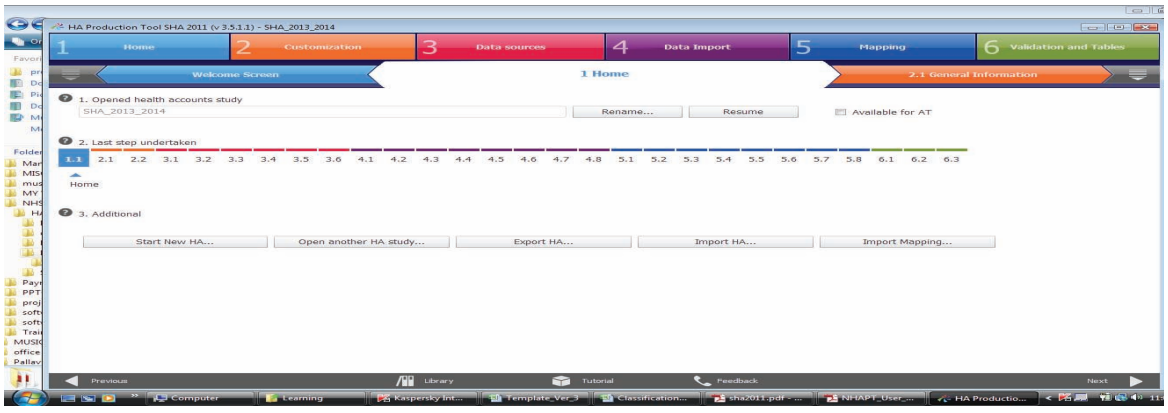
Note: Refer the step by step instructions along with the HAPT guide for detailed instructions[110]

8.1.1 Setup HAPT tool

This mainly consists of giving a name to the NHA study as shown in **Figure 8.2**.

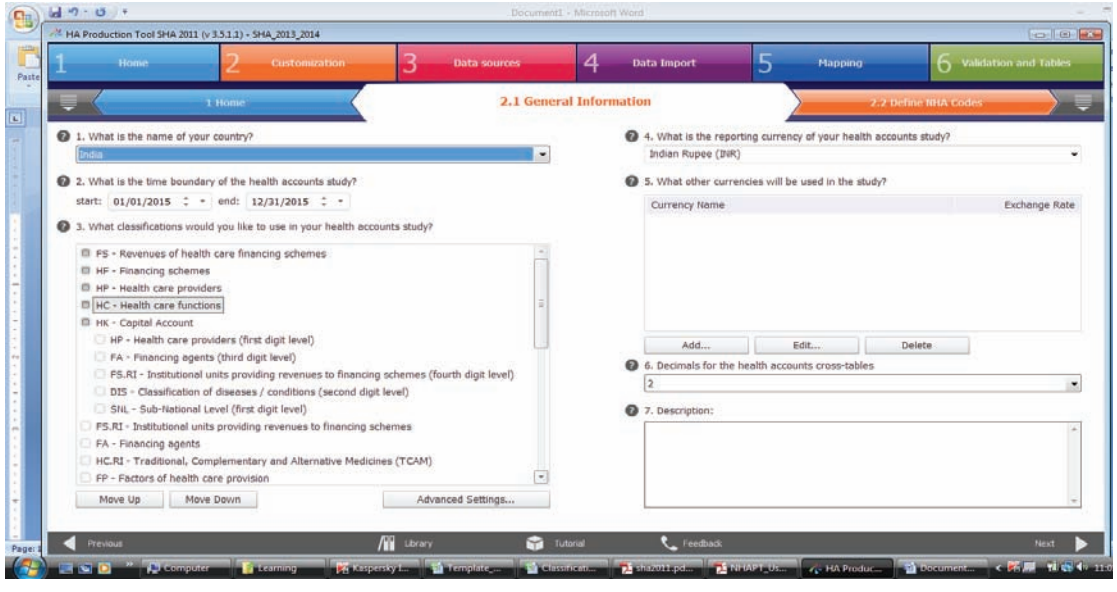
89 http://www.who.int/health-accounts/tools/HAPT/en/

Figure 8.2: Setting up HAPT (Home)



Next step in setting up HAPT, is selecting the general information required for NHA in HAPT (**Figure 8.3**). Fields FS, HF, HP, HC, HK are always selected by default. Additional fields may be selected such as beneficiaries etc. Whatever is selected here has to be mapped in the imported excel file. In other words, the imported-excel-file must have all selected fields.

Figure 8.3: Setting up HAPT (General information)



8.1.2 Define NHA codes

NHA codes defined in chapter 3 are mapped in HAPT. In HAPT, options are to manually or automatically customize the NHA codes. To automatically customize, an excel code sheet is required that can be imported into HAPT. Manual import (**Figure 8.4.a**) or automatic import (**Figure 8.4.b**) is user's prerogative. Different screenshots below elaborate these steps. These codes are important for mapping the data that would be imported in subsequent steps.

Figure 8.4.a: Defining NHA codes (Manually)

Figure 8.4.b: Defining NHA codes (Automatically)

	Description	Codes
2	Government schemes and compulsory contributory health care financing schemes	HF.1
3	Government schemes	HF.1.1
4	Union government schemes	HF.1.1.1
5	Union government schemes (Non-Employee)	HF.1.1.1.1
6	Union government schemes (Employee)	HF.1.1.1.2
7	State/regional/local government schemes	HF.1.1.2
8	State government schemes	HF.1.1.2.1
9	State government schemes (Non-Employee)	HF.1.1.2.1.1
10	State government schemes (Employee)	HF.1.1.2.1.2

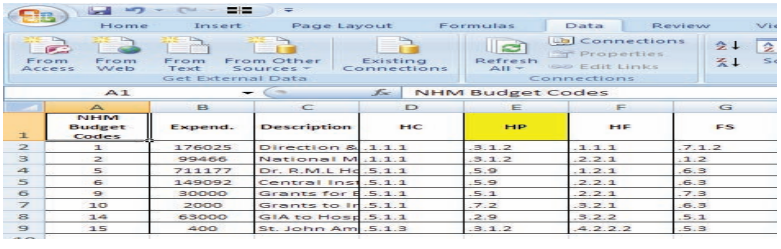
8.1.3 Process raw data into HAPT-ready format

Excel file with raw data needs to be formatted into a specific format that HAPT can understand. This again is a matter of user choice whether a manual or automatic upload is to be done. For the current study automatic excel import was done and the same is explained here.

It is important to note, the level of mapping should be till the lowest sub-digit level *e.g.* if one of the NHA code is defined as HC.1.1.1 but in the excel file is mapped till first digit only and written as 1.1 then the mapping diagram would not show correct mapping.

HAPT-ready file created from raw file looks like **Figure 8.5** after mapping is completed in excel.

Figure 8.5: HAPT ready file with mapped SHA codes

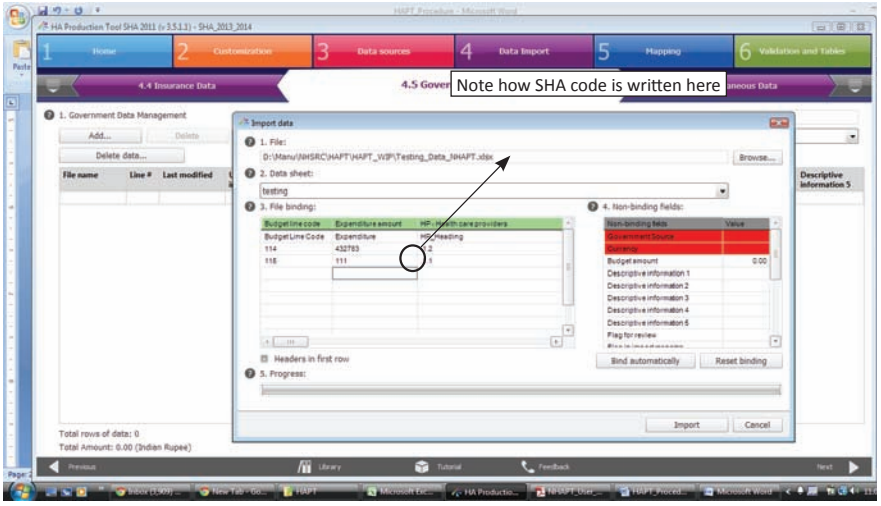


	A	B	C	D	E	F	G
1	NHM Budget Codes	Expend.	Description	HC	HP	HF	FS
2	1	176025	Direction &	.1.1.1	.3.1.2	.1.1.1	.7.1.2
3	2	99466	National M	.1.1.1	.3.1.2	.2.2.1	.1.2
4	5	711177	Dr. R.M.L Ho	.5.1.1	.5.9	.1.2.1	.6.3
5	6	149092	Central Inst	.5.1.1	.5.9	.2.2.1	.6.3
6	9	30000	Grants for E	.5.1.1	.5.1	.2.2.1	.7.3
7	10	2000	Grants to In	.5.1.1	.7.2	.3.2.1	.6.3
8	14	63000	GIA to Hosp	.5.1.1	.2.9	.3.2.2	.5.1
9	15	400	St. John Am	.5.1.3	.3.1.2	.4.2.2.2	.5.3

8.1.4 Import data catalogue

Once this excel file in HAPT-ready format is imported, the HAPT looks into the file and binds/maps fields in excel file with those defined in HAPT. This requires use of correct format, for example in the screen shot below, note how SHA code is written in excel (HP.1.2 and HP.1.1 are written as. 1.2 and .1.1). All excel raw data is mapped row-by-row with the NHA codes in similar manner. **Figure 8.6** below shows how an import looks in the HAPT

Figure 8.6: Importing and binding data into HAPT



If the entire excel-template gets mapped in HAPT then the item1 would show 100% mapping as shown in Figure 8.8. If any item is not mapped, the mapping would be less than 100%. Whether all the data has been imported can further be checked by looking into the import results message that HAPT flashes after the import is done from excel as shown below in **Figure 8.7**.

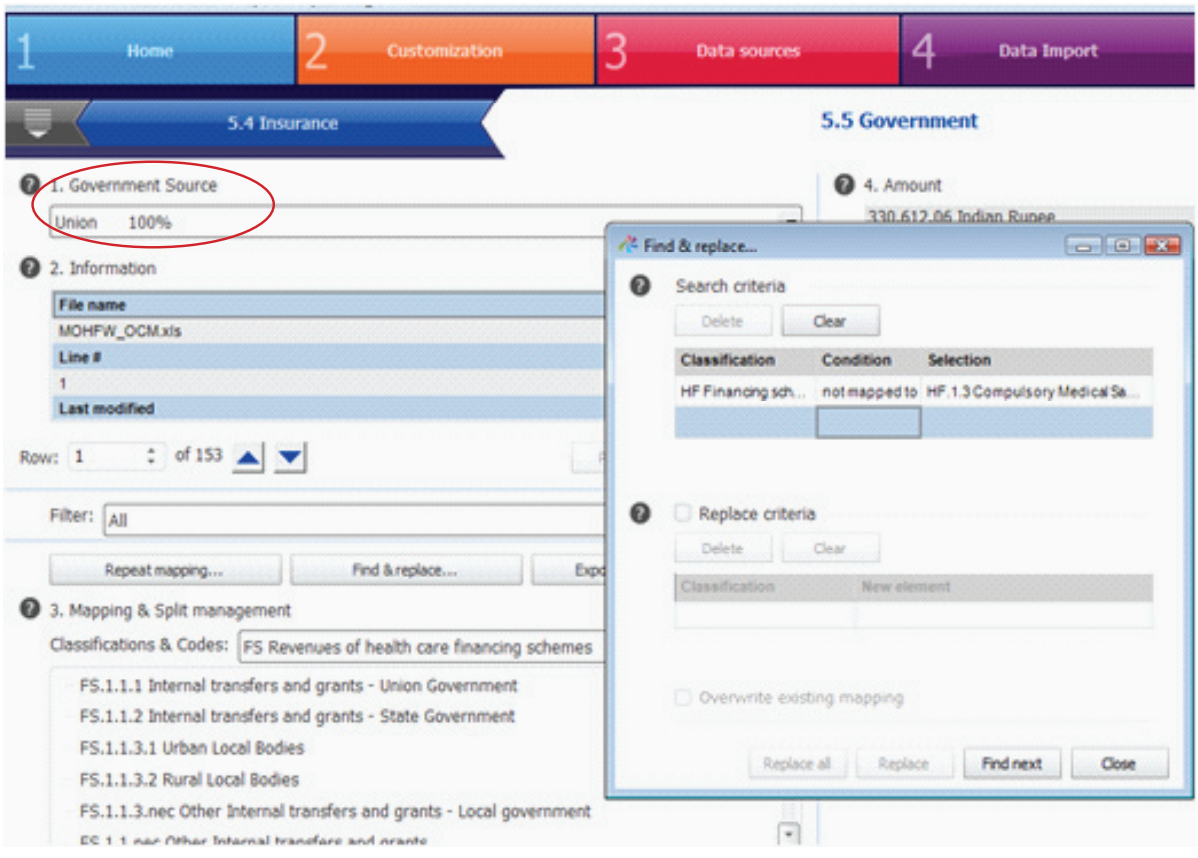
Figure 8.7: Import results

The Mapping Tree would also highlight unmapped line items (refer HP.1.1 in figure 8.10). However, if the excel template or the imported data is large then it becomes difficult to identify the unmapped items. Further, the wrong mapping could be because a specific classification in one category might not match to a classification under other category (eg – FS.3.2 does not map to HF.3.1 as "Social Insurance Contribution from Employees cannot be revenue of this scheme").

To resolve these issues here are few useful tips:

a. use find and replace to delete a mapping that has been used for multiple line items and is not required (refer **Figure 8.8**)

Figure 8.8: Find and replace mapping



b. use Export Mapping to export the data into excel sheet. This would show all the mapping and also the unmapped data would be shown as blanks. By comparing this with template the un-mapped items can be easily listed. Also, use filter to see the line items that are unmapped, for review etc as shown in **Figure 8.9**.

Figure 8.9: Export mapping

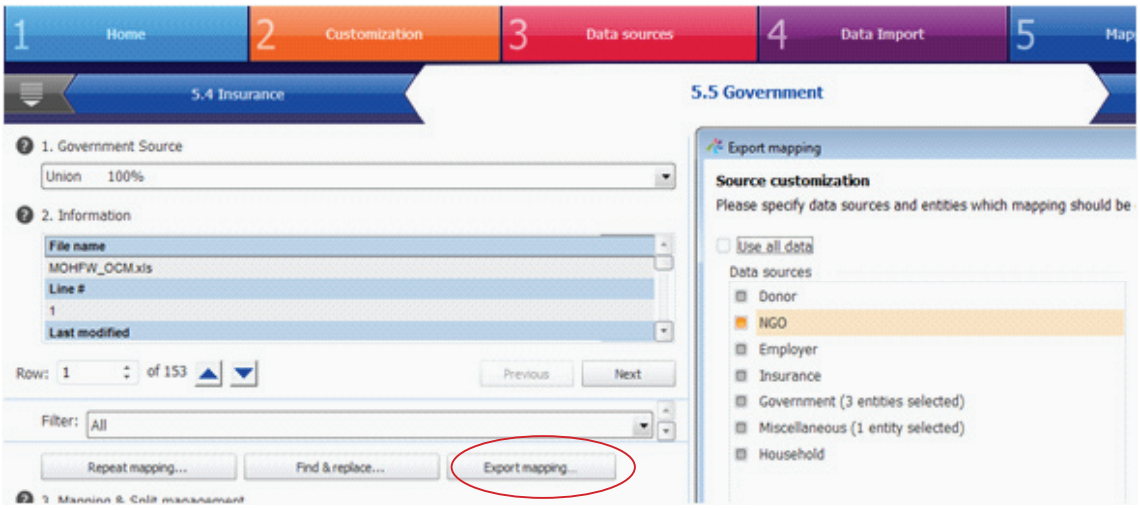
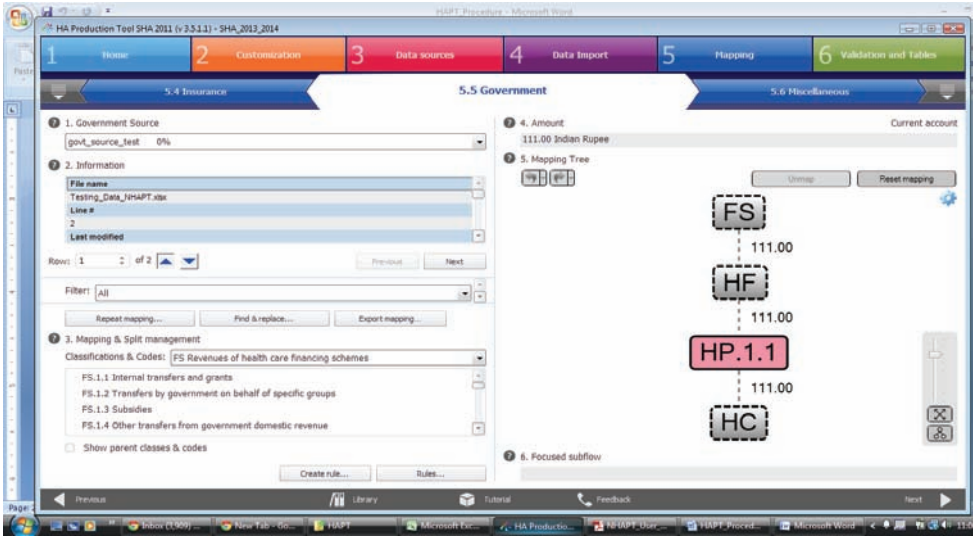
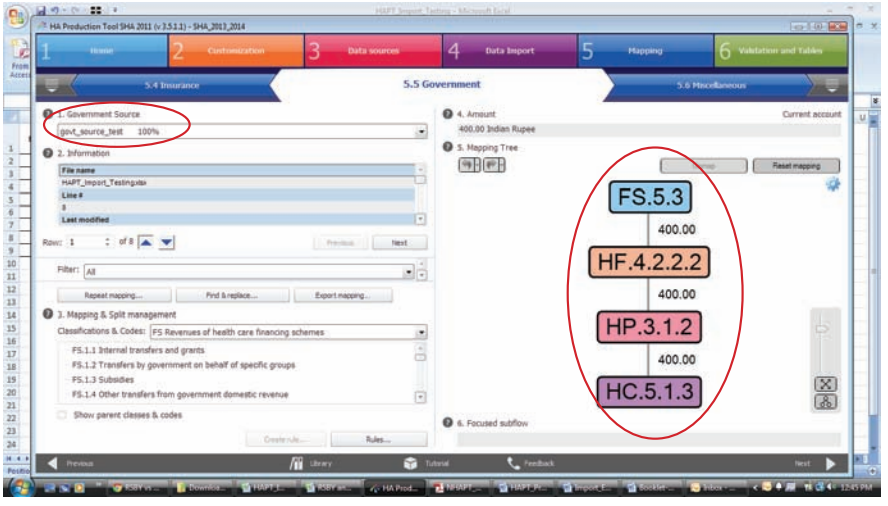


Figure 8.10: Mapping tree with incomplete mapping



An example of 100% mapping is shown in the screen shot below (**Figure 8.11**):

Figure 8.11: Mapping tree with complete mapping



8.2 Splitting Expenditures

At times, a single expenditure needs to be split across multiple codes in a classification. To split expenditure or to allocate expenditure line items across multiple classification code, you will need to define a split rule, which will establish what percentage or fraction of the expenditure is allocated to each classification in the split. You can also use split rules that have already been defined. The ratios for the rules to be applied are developed outside the tool usually using utilization and costing information as a basis. **Figure 8.12** and **8.13** below show splits done in HAPT.

Figure 8.12: Creating and selecting rules for splitting expenditure

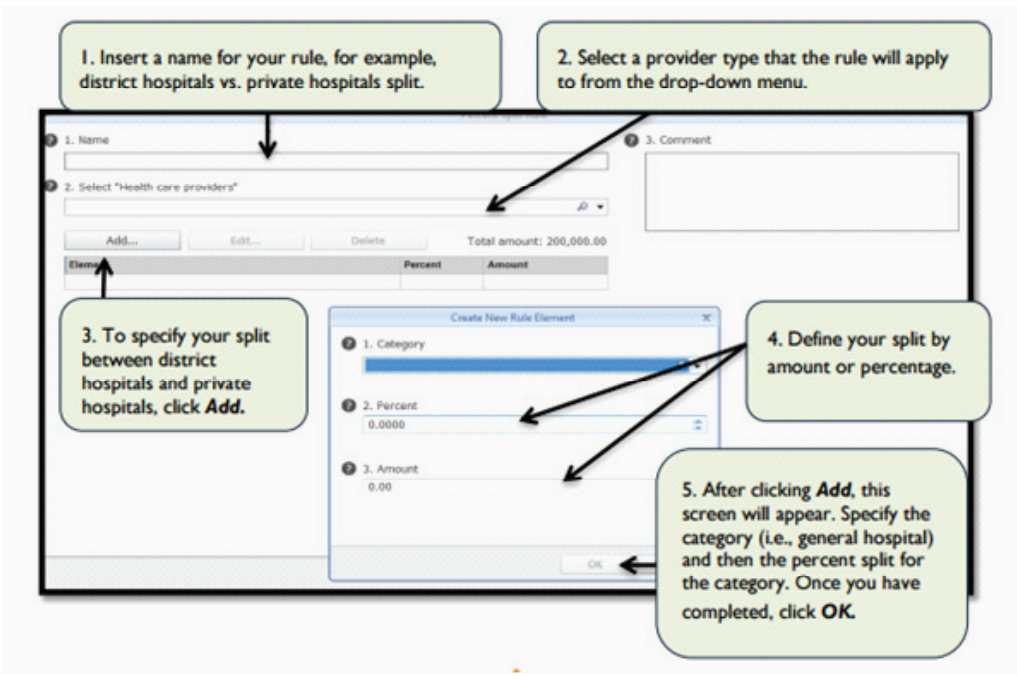
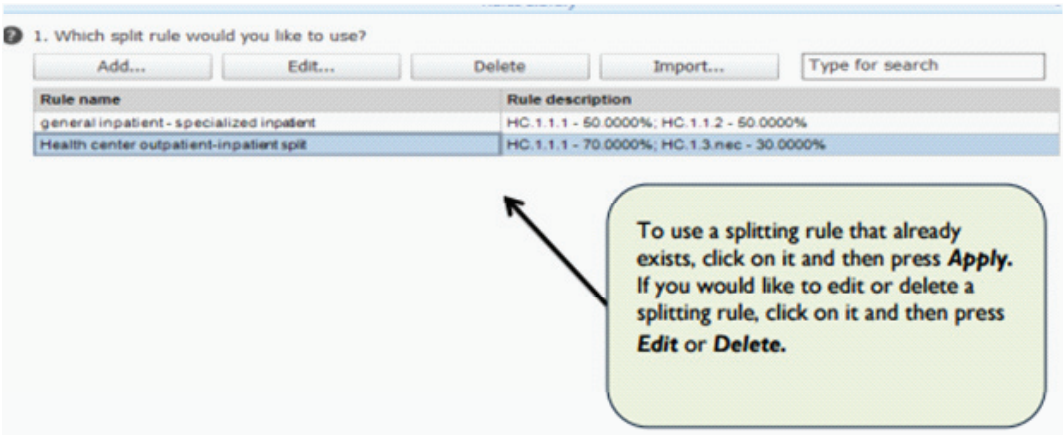


Figure 8.13: Select rule for splitting



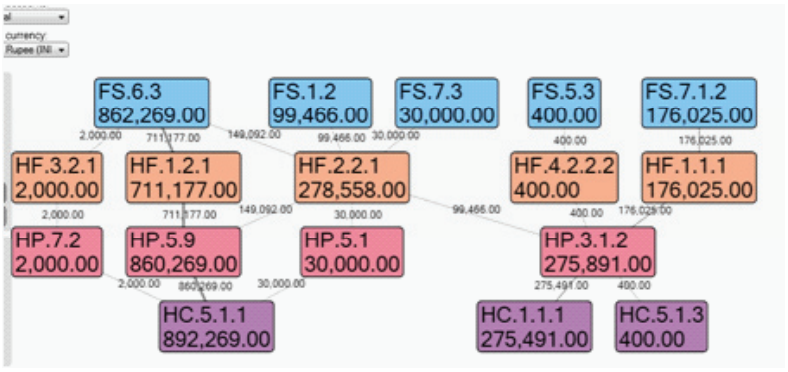
8.3 Output from HAPT

Major outputs from HAPT include graph (which primarily is the mapping tree) and the tables. These have been elaborated below with snapshots.

8.3.1 Output as mapping tree

The graph/mapping tree shows flow of funds through FS, HF, HP.and HC.(**Figure 8.14**). This in turn is helpful in getting a bird's-eyeview of entire Health Accounts landscape. HAPT provides features to change the aggregation level (ie.upto which digit level the aggregation is required), gives option to change the way the graph appear.

Figure 8.14: Output as mapping tree



8.3.2 Output as tables

HA tables described in this chapter are two-dimensional tables which represent a specific type of health financial transaction or resource flow, where the flows on one side are the origins of the funds and on the other side the recipients or the uses of those funds. By convention, the columns of the HA tables show the "origins", and the rows the recipients or "uses" of the resource flows. The labels of HA tables refer first to the row classification (uses) and then the column classification (origin), *e.g.* the table showing the resource flow from financing schemes (HF) to providers (HP) is referred to as the HPxHF.table. The sequence of transactions or resource flows through the healthcare system can be captured through a series of HA tables. These tables shown in figures 8.15, 8.16, 8.17 and 8.18(shown partially) are the main outputs of HAs and the numbers derived in these tables will always add up across rows and columns to total current health expenditure.

8.3.2.1 Health expenditure by type of financing scheme and by function (HCxHF)

The table in **Figure 8.15** showing health expenditure by type of financing scheme and type of unction describes the overall and specific allocation of resources to the major types of healthcare services by the financing schemes. This table highlights the resource paths that are key for informing health analysts. It addresses the question of" who funds what" and allows the identification of both these functions where resources are concentrated and their main funding paths. Experience shows this table to be important for validating estimates of the demand side of current health spending. The column total show the amount of resources spent under each scheme and the row totals show the amount spent under each function

Figure 8.15 HC.x HF

Financing schemes / Health care functions				HF.1	HF.1.1	HF.1.1.1	HF.1.1.1.1	All HF	Memorandum items	HF.RI.2
				Government schemes and compulsory contributory health care financing schemes	Government schemes	Central government schemes	Union government schemes (Non-Employee)			Financing schemes and the related cost-sharing together / Governmental schemes and compulsory contributory health insurance schemes together with cost sharing (HF.1 + HF.3.2.1)
HC.1			Curative care							
	HC.1.1		Inpatient curative care							
		HC.1.1.1	General inpatient curative care	X						
		HC.1.1.2	Specialised inpatient curative care							
	HC.1.3		Outpatient curative care							
		HC.1.3.1	General outpatient curative care			Y				
	HC.1.4		Home-based curative care							

Note: In figure above, 'X' shows the amount spent under all government schemes for inpatient care Similarly 'Y' shows the amount spent under central government schemes for general outpatient curative care.

8.3.2.2 Health expenditure by type of provider and by function (HCxHP)

The table in **Figure 8.16** showing current health expenditure by type of provider and by function shows how expenditures on different health functions are channeled through the various types of providers. That is, it tells the user "who provides what". This table provides a summary perspective of the health market in a country, *i.e.* what is the structure of its healthcare needs and who are the providers involved. This table has been shown to be valuable for validating the supply side of the CHE estimate.

Figure 8.16 HC.x HP

Health care functions				Health care providers	HP.1	HP.1.1	HP.1.1.1	HP.1.2	HP.1.2.1	HP.1.3	HP.1.3.1	HP.3	HP.3.3	HP.3.4	HP.3.4.1	HP.3.4.9	HP.4	HP.4.1	HP.6	HP.7	HP.7.1	All HP
					Hospitals	General hospitals	General hospitals ? Government	Mental health hospitals	Mental Health hospitals ? Government	Specialised hospitals (Other than mental health hospitals)	Specialised hospitals (Other than mental health hospitals) Government	Providers of ambulatory health care	Other health care practitioners	Ambulatory health care centres	Family planning centres	All Other ambulatory centres	Providers of ancillary services	Providers of patient transportation and emergency rescue	Providers of preventive care	Providers of health care system administration and financing	Government health administration agencies	
HC.1				Curative care																		
	HC.1.1			Inpatient curative care																		
		HC.1.1.1		General inpatient curative care																		
		HC.1.1.2		Specialised inpatient curative care																		
	HC.1.3			Outpatient curative care																		
		HC.1.3.1		General outpatient curative care																		
	HC.1.4			Home-based curative care																		

8.3.2.3 Health expenditure by financing scheme and by type of provider (HPxHF)

Figure 8.17 depicting HPxHF.shows the structure of current health expenditure according to the financing arrangements (financing schemes) for providing the financial means to the providers. It describes how funds are distributed across different types of providers and addresses the question, "who funds who". It identifies those providers where resources are concentrated and their funding path. It is an important tool for estimating total current health spending

Figure 8.17 HP.x HF

Health care providers				Financing schemes	HF.1	Government schemes and compulsory contributory health care financing schemes	HF.1.1	Government schemes	HF.1.1.1	Central government schemes	HF.1.1.1.1	Union government schemes (Non-Employee)	All HF	Memorandum items	HF.RI.2	Financing schemes and the related cost-sharing together	Government schemes and compulsory contributory health insurance schemes together with cost sharing (HF.1 + HF.3.2.1)
HP.1				Hospitals													
	HP.1.1			General hospitals													
		HP.1.1.1		General hospitals ?Government													
	HP.1.2			Mental health hospitals													
		HP.1.2.1		Mental Health hospitals ?Government													
	HP.1.3			Specialised hospitals (Other than mental health hospitals)													
		HP.1.3.1		Specialised hospitals (Other than mental health hospitals) Government													

8.3.2.4 Types of revenues by revenues of the financing scheme (HFxFS)

The table in **Figure 8.18** shows the financing path to fund the various schemes. The institutional units collect the funds used to finance the schemes. Key question addressed here is "where does the money come from" by showing the types of revenue of each financing scheme. The table also tells relative importance of each type of revenue in the financing of each financing scheme and in total current spending over all.

Figure 8.18 HF.x FS

Financing schemes	Revenues of health care financing schemes	FS.1 Transfers from government domestic revenue (allocated to health purposes)	FS.1.1 Internal transfers and grants	FS.1.1.1 Internal transfers and grants - Union Government	FS.2 Transfers distributed by government from foreign origin	FS.2.1 Transfers distributed by Union Government from foreign origin	All FS
HF.1	Government schemes and compulsory contributory health care						
HF.1.1	Government schemes						
HF.1.1.1	Central government schemes						
HF.1.1.1.1	Union government schemes (Non-Employee)						
All HF							

8.4 Converting HAPT outputs into National Health Accounts Indicators and Report

8.4.1 Health account indicators

"If health accounts are to be viewed as a measuring tool, the indicators are the measurements or readings derived from this tool." – SHA 2011

The indicators convert the raw data into values that policy makers use for interpreting the data. These define the health financing functions of revenue raising, pooling and purchasing. The indicators can be derived from the health account results or in combination with other macro-economic and non-expenditure data. Indicators of the first type include absolute expenditure levels, percentage shares to total and ratios of one health accounts component to another. Indicators of the second type include share of GDP, per capita values and values converted using exchange rates or PPPs. These indicators when presented through the cross-tabulations give targeted insights into the overall health system. Some examples of healthcare indictors that can be derived from National Health Account tables are presented in **Table 8.1.**

Table 8.1: Examples of indicators used in healthcare analysis (source SHA 2011)

Axis(1)	Indicators(2)	Crores INR(3)	% GDP/ GSDP(4)	Per capita INR(5)	%CHE(6)	%THE(7)
General	Total current health expenditure	✓	✓	✓	✗	✓
	Total current health expenditure plus capital spending	✓	✓	✓	✗	✗

Axis(1)	Indicators(2)	Crores INR(3)	% GDP/ GSDP(4)	Per capita INR(5)	%CHE(6)	%THE(7)
Health Functions	Preventive spending	✓	✗	✗	✓	✓
	Curative spending	✓	✗	✗	✓	✓
	Inpatient spending	✓	✗	✗	✓	✓
	Outpatient spending	✓	✗	✗	✓	✓
	Total Pharmaceutical Expenditures	✓	✓	✓	✓	✓
	Expenditure on Traditional Complementary and Alternative Medicine (TCAM)	✓	✓	✓	✓	✓
Financing Schemes	Government health schemes	✓	✓*	✓	✓	✓
	Union Government Health Schemes	✓	✓*	✓	✓	✓
	State Government Health Schemes	✓	✓*	✓	✓	✓
	Urban Local Bodies Health Schemes	✓	✓	✓	✓	✓
	Rural Local Bodies Health Schemes	✓	✓	✓	✓	✓
	Compulsory contributory health insurance schemes	✓	✗	✗	✓	✓
	Voluntary health insurance schemes	✓	✗	✗	✓	✓
	Out-of-pocket expenditure on health	✓	✓	✓	✓	✓
Providers	Hospital health spending (Total)	✓	✗	✗	✓	✓
	Hospital health spending – Public	✓	✗	✗	✓	✓
	Hospital health spending – Private	✓	✗	✗	✓	✓
	Ambulatory health spending (Total)	✓	✗	✗	✓	✓
	Ambulatory health spending – Public	✓	✗	✗	✓	✓
	Ambulatory health spending – Private	✓	✗	✗	✓	✓
Revenue of schemes	Total Government Health Expenditure (Current plus Capital)	✓	✓	✓	✓	✓
	Government Health Expenditure (Current)	✓	✓	✓	✓	✓
	Union Government Health Expenditure (Current)	✓	✓	✓	✓	✓
	State Government Health Expenditure (Current)	✓	✓	✓	✓	✓
	Urban Local Bodies Health Expenditure (Current)	✓	✓	✓	✓	✓
	Rural Local Bodies Health Expenditure (Current)	✓	✓	✓	✓	✓
	Privately funded expenditure on health	✓	✓	✓	✓	✓
	Household Health Expenditures (OOP + Prepayment for Social Health Insurance + Government based voluntary health insurance + Private Health Insurance)	✓	✓	✓	✓	✓
	Externally funded expenditure on health	✓	✗	✗	✓	✓
Factors of Production	Government Expenditure on human resources	✓	✓	✓	✓	✓
	Expenditure on drugs and consumables	✓	✓	✓	✓	✓
Beneficiaries	Expenditure on health on non-communicable diseases	✓	✗	✗	✓	✓
	Expenditure on health on communicable diseases	✓	✗	✗	✓	✓
Capital Formation	Total Public Spending on capital formation	✓	✗	✗	✓	✓
	Total spending on capital formation	✓	✗	✗	✓	✓

Source: GDP and GSDP figures can be sourced from Ministry of Statistics and Program Implementation web-site (link: http://mospi.nic.in/Mospi_New/site/inner.aspx?status=3&menu_id=82)

Note: INR=Indian Rupee; GDP=Gross Domestic Product of India; GSDP=Gross State Domestic Product; CHE=Current Health Expenditure;

• These number should also be shown as a proportion of General Government Expenditures

The indicators in the list are computed either using purely HA results or in combination with additional macro-economic and non-expenditure data. Indicators of the first type include absolute expenditure levels, percentage shares to total and ratios of one health accounts component to another. Indicators of the second type include share of GDP, per capita values.

The absolute values (column 3) of most of the above mentioned indicators could be obtained from the 2x2 matrix (i.e. cross tabulation) explained in the earlier sections. For example the total value of "Hospital health spending" is the row total of HP.1 Hospitals in the 2x2 matrix for healthcare financing schemes and healthcare providers (HFxHP). Similarly the absolute values of other indicators can be obtained from these 2x2 matrices or tables. The method for calculating absolute values for factors of provision and capital formation are explained in respective sections of the guideline.

There are certain indicators that are important for the policy maker and international or inter-state comparisons. These are all simple mathematical calculations for obtaining percentages. The final set of indicators are calculated as a percentage of the current health expenditure, for example publicly funded expenditure on healthcare as a percentage of current health expenditure. The absolute value of Total Current Health Expenditure (CHE) in column 3 should be used as the denominator for calculating this indicator. Some of these indicators and their methodology to calculate are given in **Table 8.2** below.

Table 8.2: Key indicators and their methods of estimation

Sr. No	Indicator	As ratios	Method
1	Total Health Expenditure (THE) as a percentage of Gross Domestic Product (GDP)	(Total Current Health Expenditure + Total Capital Formation) as a percentage of GDP	Add total current expenditure and total capital formation and divide it with the GDP of India in current prices for the year and multiply by 100
2	Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	CHE as a percentage of GDP (at current prices)	Divide CHE by the GDP of India in current prices for the year and multiply by 100
3	Current Health Expenditure per Capita		Divide CHE by mid year population of India for the year
4	Government Health Schemes % Current Health Expenditure	HF.1.1%CHE	Add all HF.1.1 and divide the total by CHE and multiply by 100
4.1	Union Government Schemes % Current Health Expenditure	HF.1.1.1%CHE	Add all HF.1.1.1 and divide the total by CHE and multiply by 100
4.2	State Government Schemes % Current Health Expenditure	HF.1.1.2.1%CHE	Add all HF.1.1.2.1 and divide the total by CHE and multiply by 100
4.3	Local Government Schemes % Current Health Expenditure	HF.1.1.2.2%CHE	Add all HF.1.1.2.2 and divide the total by CHE and multiply by 100
4.3.1	Urban Local Bodies Schemes % Current Health Expenditure	HF.1.1.2.2.1%CHE	Add all HF.1.1.2.2.1 and divide the total by CHE and multiply by 100
4.3.2	Rural Local Bodies Schemes % Current Health Expenditure	HF.1.1.2.2.2%CHE	Add all HF.1.1.2.2.2 and divide the total by CHE and multiply by 100
5	Social Health Insurance Schemes % Current Health Expenditure	HF.1.2.1%CHE	Add all HF.1.2.1 and divide the total by CHE and multiply by 100
6	Voluntary Healthcare Payment Schemes % Current Health Expenditure	HF.2%CHE	Add all HF.2 and divide the total by CHE and multiply by 100
7	Out-of-Pocket Spending as % Current Health Expenditure	OOPS%CHE	Divide Total FS.6.1 by CHE and multiply by 100
8	Not for Profit Institutions Serving Households Schemes as % Current Health Expenditure	HF.2.2%CHE	Add all HF.2.2 and divide the total by CHE and multiply by 100
9	Enterprises schemes as % Current Health Expenditure	HF.2.3%CHE	Add all HF.2.3 and divide the total by CHE and multiply by 100
10	Domestic General Government Funds for Health % Current Health Expenditure	FS.1%CHE	Add all FS.1 and divide the total by CHE and multiply by 100
10.1	Domestic Union Government Funds for Health as % Current Health Expenditures	FS.1.1.1%CHE	Add all FS.1.1.1 and divide the total by CHE and multiply by 100

Sr. No	Indicator	As ratios	Method
10.2	Domestic State Government Funds for Health as % Current Health Expenditures	FS.1.1.2%CHE	Add all FS.1.1.2 and divide the total by CHE and multiply by 100
10.3	Domestic Urban Local Bodies Funds for Health as % Current Health Expenditures	FS.1.1.3.1%CHE	Add all FS.1.1.3.1 and divide the total by CHE and multiply by 100
10.4	Domestic Rural Local Bodies Funds for Health as % Current Health Expenditures	FS.1.1.3.2%CHE	Add all FS.1.1.3.2 and divide the total by CHE and multiply by 100
11	External Funds for Health % Current Health Expenditure	FS.2.7%CHE	Add all FS.2 and FS.7 and divide the total by CHE and multiply by 100
12	Compensation of Employees as % Current Health Expenditure	HRH%CHE	Divide total FP.1 by total CHE and multiply by 100
13	Total Pharmaceutical Expenditure as % Current Health Expenditure	TPE%CHE	Divide total HC.RI.1 by total CHE and multiply by 100
14	TCAM expenditures as % Current Health Expenditure	TCAM%CHE	Divide total HC.RI.2 by total CHE and multiply by 100
15	Expenditure on Inpatient care as % Current Health Expenditure	HC.1.1%CHE	Add all HC.1.1 and divide the total by CHE and multiply by 100
16	Expenditure on Outpatient care as % Current Health Expenditure	HC.1.3%CHE	Add all HC.1.3 and divide the total by CHE and multiply by 100
17	Expenditure on Preventive care as % Current Health Expenditure	HC.6%CHE	Add all HC.6 and divide the total by CHE and multiply by 100
18	Expenditure on Hosptials as % Current Health Expenditure	HP.1%CHE	Take the total of HP.1 and divide it by CHE and multiply by 100
18.1	Expenditure on Hospitals - Government as % Current Health Expenditure	HP.1.1.1%CHE	Add all HP.1.1.1 and divide the total by CHE and multiply by 100
18.2	Expenditure on Hospitals - Private as % Current Health Expenditure	HP.1.1.2%CHE	Add all HP.1.1.2 and divide the total by CHE and multiply by 100
19	Expenditure on Ambulatory Healthcare centres as % Current Health Expenditure	HP.3.4%CHE	Add all HP.3.4 and divide the total by CHE and multiply by 100
20	Primary Care % Current Health Expenditure		From HPxHC matrix
21	Secondary Care % Current Health Expenditure		From HPxHC matrix
22	Tertiary Care % Current Health Expenditure		From HPxHC matrix

List of Members of the Steering Committee

1	Secretary Department of Health and Family Welfare	**Chairman**
2	Secretary Department of AIDS Control Ministry of Health and Family Welfare	Member
3	Secretary Department of AYUSH Ministry of Health and Family Welfare IRCS Building Annexe, 1, Red Cross Road, New Delhi – 110001	Member
4	Secretary Department of Health Research Ministry of Health and Family Welfare V. Ramalingaswami Bhawan Ansari Nagar, New Delhi – 110029	Member
5	Director General of Health Services Ministry of Health and Family Welfare Nirman Bhawan New Delhi – 110011	Member
6	Additional Secretary & Mission Director (NHM) Ministry of Health and Family Welfare Nirman Bhawan New Delhi – 110011	Member
7	Additional Secretary & Financial Advisor Ministry of Health and Family Welfare Nirman Bhawan New Delhi - 110011	Member
8	Additional Secretary (Health) Ministry of Health and Family Welfare	Member
9	Additional Director General Central Statistical Organisation Sardar Patel Bhawan, Parliament Street New Delhi – 110001	Member
10	Advisor (Health) Planning Commission Government of India Yojana Bhawan, Sansad Marg New Delhi – 110001	Member
11	Director General Employees State Insurance Corporation Comrade Inderjeet Gupta (CIG) Marg New Delhi – 110002	Member

12	Director General &CEO National Sample Survey Organisation Ministry of Statistics and Programme Implementation Sardar Patel Bhawan, Parliament Street, New Delhi – 110001	Member
13	Chairman Insurance Regulatory and Development Authority 3rd Floor, Parisrama Bhawan Basheer Bagh, Hyderabad – 500004 Andhra Pradesh	
14	Economic Advisor Ministry of Health and Family Welfare Nirman Bhawan New Delhi – 110011	Member
15	Joint Secretary (Fund Bank) Department of Economic Affairs North Block New Delhi – 110001	Member
16	WHO Representative to India Nirman Bhawan Maulana Azad Road New Delhi – 110011	Member
17	Joint Secretary / Director General (Labour Welfare) Ministry of Labour and Employment Shram Shakti Bhawan Rafi Marg, New Delhi – 110001	Member
18	Joint Secretary (Foreigners Division) Ministry of Home Affairs, NDCC Building New Delhi – 110001	Member
19	Controller of Aid Accounts & Audit Department of Economic Affairs Janpath Bhawan, B Wing, 5th Floor	Member
20	Controller General of Accounts Department of Expenditure Ministry of Finance Lok Nayak Bhawan New Delhi	Member
21	Principal Secretary (Health) Government of Karnataka	Member
22	Principal Secretary (Health) Government of Tamilnadu	Member
23	Principal Secretary (Health) Government of Gujarat	Member
24	Executive Director National Health Systems Resource Centre NIHFW Campus Baba Gangnath Marg Munirka, New Delhi – 110067	Member Secretary

List of Members of NHA Expert Group

1	Economic Advisor Department of Health and Family Welfare	Chairperson
2	Deputy Director General, National Accounts Division Central Statistical Organization	Member
3	Deputy Director General, National Sample Survey Organisation (In charge of 71st round of Socio-Economic Survey on health and education)	Member
4	Director (NAD), CSO, Ministry of Statistics &Programme Implementation	Member
5	Representative of National Institute of Public Finance & Policy (NIPFP, New Delhi	Member
6	Representative, Health Policy Research Unit, Institute of Economic Growth, New Delhi	Member
7	Representative of Health Division, Planning Commission	Member
8	Director Bureau of Planning, DoHFW	Member
9	Senior Public Health Specialist (Health Economics), PHFI, New Delhi	Member
10	Representative, Institute of Health Management Research, Jaipur	Member
11	Representative of Ministry of Drinking Water Supply Sanitation, 9th Floor, ParyavaranBhawan, CGO Complex, New Delhi – 110003	Member
12	Representative of National Council of Applied Economic Research (NCAER) New Delhi	Member
13	Representative of Foreigners Division, Ministry of Home Affairs, NDCC Building, New Delhi – 110001	Member
14	Representative of WHO, New Delhi	Member
15	Representative of National Health Accounts Technical Secretariat (NTS) NHSRC	Member Secretary

Survey Formats Used

A1. Format for Information Collection from the Corporation/Council

Health services under the urban local bodies in India

Section 1: Basic Information			
Q. No.	Question	Categories	Code
	Name of State		
	Name of District		
	Type of Urban Local Body	Municipal Corporation	1
		Municipality Council	2
		Notified area Council	3
	Name of Urban Local Body		
	Population Covered		
	Number of Wards		
	Year of Establishment		

Q. No.	Question	Number
	Medical College	
	Hospitals	
	Dispensaries	
	Urban Family Welfare Centre	
	Urban health posts	
	Maternity Homes	
	Other health facilities *(please mention the types)*	

Section 3: Manpower for Out-Patient Facility (UHP,UFWP,Dispensary,.....)								
Specialists			Other Medical and Para-medical staff			Support Staff		
Q. No.	Specialization	No	Q. No.	Category	No.	Q. No.	Category	No.
	Dentist			Medical Officer			Clerks	
	Pediatrician			Lady Health Visitor			Accountant	
	Obst./ Gynecologist			Basic Health Worker (Male)			Computer Operator	
	Eye specialist			Basic Health worker (Female)			Driver	
	ENT specialist			Nurse			Sweeper	
	Cardiologist			Health Educator				
	General medicine			Pharmacist				
	Gastroenterologist			Lab Technician				
	Others (specify)			Health Assistant			Others (specify)	
	Others (specify)			Others (specify)			Others (specify)	
	Others (specify)			Others (specify)			Others (specify)	

Section 4: Manpower for In-Patient Facility (Hospitals, Maternity Homes.....)								
Specialists			**Other Medical and Para-medical staff**			**Support Staff**		
Q. No.	**Specialization**	**No.**	**Q. No.**	**Category**	**No.**	**Q. No.**	**Category**	**No.**
	Dental Surgeon			Hospital Superintendent			Clerks	
	Radiologist			General Physician			Accountant	
	Pediatrician			General Surgeon			Computer Operator	
	Anesthetist			Medical Officer			Ward Boy	
	Eye Surgeon			Lady Health Visitor			Driver	
	Obstetrician / Gynecologist			Basic Health Worker (Male)			Sweeper	
	Dermatologist			Basic Health worker (Female)			Others (specify)	
	Forensic Specialist			Pharmacist			Others (specify)	
	ENT Surgeon			Nurse			Others (specify)	
	Pulmonologist			Midwife			Others (specify)	
	Hematologist			Health Educator			Others (specify)	
	Gastroenterologist			Health Assistant		ON CALL		
	Dermatologist			Laboratory Technician				
	Endocrinologist			ASHA				
	Cardiologist			AWW				
	General Medicine			Others (specify)				
	Neurologist			Others (specify)				
	Rheumatologist			Others (specify)				
	Nephrologist			Others (specify)				
	Oncologist			Others (specify)				

Section 5.1: Utilization of Health Facilities							
Q. No.	**Question**	**Categories**					
5.1	Type of Facility	*Facility Type.....*			*Facility Type.....*		
5.2	How many out-patient cases treated during the following period?	**Period**	**Men**	**Women**	**Period**	**Men**	**Women**
		On the day before survey			On the day before survey		
		Last week			Last week		
		Last month			Last month		
		2015			2015		
		2014			2014		
		2013			2013		
		2012			2012		
5.3	Please provide the number of in-patient cases registered during the flowing period.	Period	Men	Women	Period	Men	Women
		On the day before survey			On the day before survey		
		Last week			Last week		
		Last month			Last month		
		2015			2015		
		2014			2014		
		2013			2013		
		2012			2012		

Section 5.2: Utilization of Health Facilities							
Q. No.	**Question**	**Categories**					
5.2.1	Type of Facility	*Facility Type.....*			*Facility Type.....*		
5.2.2	How many out-patient cases treated during the following period?	**Period**	**Men**	**Women**	**Period**	**Men**	**Women**
		On the day before survey			On the day before survey		
		Last week			Last week		
		Last month			Last month		
		2015			2015		
		2014			2014		
		2013			2013		
		2012			2012		
5.2.3	Please provide the number of in-patient cases registered during the flowing period.	**Period**	**Men**	**Women**	**Period**	**Men**	**Women**
		On the day before survey			On the day before survey		
		Last week			Last week		
		Last month			Last month		
		2015			2015		
		2014			2014		
		2013			2013		
		2012			2012		

Section 5.3: Utilization of Health Facilities							
Q. No.	**Question**	**Categories**					
5.3.1	Type of Facility	*Facility Type.....*			*Facility Type.....*		
5.3.2	How many out-patient cases treated during the following period?	**Period**	**Men**	**Women**	**Period**	**Men**	**Women**
		On the day before survey			On the day before survey		
		Last week			Last week		
		Last month			Last month		
		2015			2015		
		2014			2014		
		2013			2013		
		2012			2012		
5.3	Please provide the number of in-patient cases registered during the flowing period.	**Period**	**Men**	**Women**	**Period**	**Men**	**Women**
		On the day before survey			On the day before survey		
		Last week			Last week		
		Last month			Last month		
		2015			2015		
		2014			2014		
		2013			2013		
		2012			2012		

Study on finances of urban local bodies in India

Section 6: Receipt of the Selected ULB (in Rs. 000)				
Q. No.	**Question**	**2011-12**	**2012-13**	**2013-14**
REVENUE RECEIPTS				
6.1	Tax Revenue			
6.1.1	Taxes on property			
6.1.2	Taxes on Vehicles			
6.1.3	Taxes on Advertisements and Hoardings			
6.1.4	Entertainment Tax			
6.1.5	Pilgrim Tax			

Q. No.	Question	2011-12	2012-13	2013-14
6.1.6	Octroi Tax			
6.1.7	Professional Tax			
6.2	Non Tax Revenue			
6.2.1	User Charges			
6.2.2	Fees and Fines			
6.2.3	Rent from Municipal Assets			
6.2.4	Interest from Investments			
6.2.5	Dividends			
6.2.6	Others			
Total – Revenue Receipts (6.1+6.2)				
GRANTS & AID FROM STATE & CENTRAL GOVERNMENT				
6.3	State Government Grants			
6.3.1	General Purpose Grants			
6.3.2	Special Purpose Grants			
6.3.3	Special Purpose Grants on Health			
6.3.4	Share in State Taxes			
6.3.5	Others			
6.4	Central Government Grants			
6.4.1	Finance commission Grants			
6.4.2	Central Government Schemes			
6.4.3	General Purpose Grants			
6.5	Donations, MP, MLA Funds etc			
Total Grants & Aid (6.3+6.4+6.5)				
CAPITAL ACCOUNT RECEIPTS				
6.6	Capita Account Receipts			
6.6.1	Loans From State Governments			
6.6.2	Loans From Other Development Partners			
6.6.3	Market Borrowings			
6.6.4	Others			
6.6.5	Disinvestment			
Total of Capital Account Receipts				
GRAND TOTAL (REVENUE + CAPITAL + GRANTS & AID)				

- *Octori Tax may not be at all Urban Local Bodies*

Section 7: Expenditure of the Selected ULB (in Rs. 000)				
Q. No.	**Question**	**2011-12**	**2012-13**	**2013-14**
REVENUE EXPENDITURE				
7.1	Administrative Expenditure			
7.1.1	Wages and Salaries			
7.1.2	Operation and Maintenance			
7.1.3	Interest and debt			
7.1.4	Medical Reimbursement/ Benefits			
7.1.5	Others			
7.2	Expenditure on core Services			
7.2.1	Water supply			
7.2.2	Sewerage & Drainage			

Q. No.	Question	2011-12	2012-13	2013-14
7.2.3	Conservancy & Sanitation			
7.2.4	Solid Waste Management			
7.2.5	Municipal Roads			
7.2.6	Street Lighting			
7.2.7	Healthcare			
7.2.8	Other Activities			
Total – Revenue Expenditure (7.1+7.2)				
CAPITAL EXPENDITURE				
7.3	Capital Expenditure			
7.3.1	Creation of Physical assets (market complexes, school & hospital buildings etc.)			
7.3.2	Repayment of Loans			
7.3.3	Others			
Total – Capital Expenditure (7.3.1+7.3.2+7.3.3)				
GRAND TOTAL (REVENUE + CAPITAL)				

- *Note- one need to see if salary of the staff involved in the core services are part of wages & salary or included in the service delivery expenditure*

Section 8: Health Expenditure of the Selected ULB (in Rs. 000)				
Q. No.	**Question**	**2011-12**	**2012-13**	**2013-14**
8.1 REVENUE EXPENDITURE				
8.1.1	Salary and Wages of Medical Staff			
8.1.2	Salary and wages of Contractual Staff			
8.1.3	Other Administrative Expenditure			
8.1.4	Expenditure on Medicine			
8.1.5	Other Consumables			
8.1.6	Public Health Expenditure			
8.1.7	Immunisation			
8.1.8	IEC/ Awareness Programmes			
8.1.9	Child Health			
8.1.10	Training			
8.1.11	Others			
Total – Revenue Expenditure (8.1.1 to 8.1.11)				
8.2 CAPITAL EXPENDITURE				
8.2.1	Hospitals			
8.2.2	Dispensaries			
8.2.3	Others			
Total – Capital Expenditure (8.2.1 to 8.2.3)				
GRAND TOTAL (REVENUE + CAPITAL)				

A2: Survey to Estimate Health Expenditure by Enterprises

Consent to participate in panel study

INTERVIEWER – Read Out: Namaskar. My name is (please say your name here). I have come from Market Xcel to collect some information on behalf of Public Health Foundation of India (PHFI).To understand the Expenditure on Health at the enterprise level. This will be very useful in preparing the National Health Account (NHA) for India. We will be asking you questions related to some basic information and health-expenditure related issues of your enterprise. We would appreciate your participation in this survey. The information collected would be kept confidential and anonymity of enterprises will be maintained. The information collected would be used only at the aggregate level of all the enterprises. The survey should take a short time (about 30 minutes) to complete. May I begin the interview now with your consent?

Oral consent given

Yes (continue)	1
No (Stop the interview)	2

Enterprise ID

F S SD D Sr Sr Sr

A: Identification Particulars (From A1 to A7 to be filled by official)							
A.1	Name of the Enterprise						
A.2	Frame						
A.3	Serial No. in Sample List						
A.4	Industry Code (First 4 digits- NIC 2008)						
A.5	Description of Industry						
A.6	State						
A.7	District						
A.8	Total Number of Units	Total	A8.1 (Within the state)		A8.2 (Outside the Sate)		
A.9	Name of the Interviewer						
A.10	Mode of Interview (Telephonic=1, Otherwise=2)		1		2		

Codes for A2: *Central PSU= 1, State PSU=2, Private Enterprise= 3*

B: Particulars for the Enterprise Surveyed				
B.1	Address of the Enterprise			
B.2	Name of the Informant			
B.3	Designation of the Informant			
B.4 B.5	Registered under (Circle the relevant codes) (Multiple Options Possible)	1	Indian Factory Act, 1948	
		2	Municipal Corporation/Local Body	
		3	Vat/Sales Tax Act	
		4	Provident Fund Act	
		5	Employees State Insurance	
		6	Corporation Act	
		7	Plantation Board	
		9	Others (Specify)	
	Industry Code /Division Code (Please enter two-digit NIC code given in the industry code sheet provided separately)			
B.6	Major Product (Specify)			
B.7	Other Products (Specify)	1		
		2		
		3		
B.8	Production Start Year			
B.9	Specify the month If started after March, 2014			**Ask B9 if production started after March 2014. Else GOTO next section**
B.10	No. of Months in operation during 2014-15			

C: Geographical Spread of the Enterprises Surveyed across India									
C.1 Unit Sr. No.	**C.1** Major Product	**C.3** Industry Code	**C.4** State/UT Name	**C.5** (State Code)	**C.6** District Name	Persons Employed			
						C.7 Permanent	Contract Type		
							C8.1 >=1 Year	C8.2 <1 Yr	C8.3 No Written Contract
1 (Base Location)									
2									
3									
4									
6									
7									
8									
9									
10									
12									
14									
16									
17									
18									
19									
20									
All									

D: Economic Characteristics of the Enterprise/group of units Surveyed														
D.1	Information provided for (Codes) (enterprise=1, some units together=2, one unit only=3)								2			3		
D. 2	If answer for D.1=2, then for how many no. of Units the information will be provided (If information provided for some units together)													
Instruction: If answer for **D.1= 1 or 2** fill question no. **D.3=0** and If **D.1=3** then copy the **serial no. of units** from **Section-C**														
D.3 Unit Serial No.	D.4 Gross Value of Fixed Assets (in Lakhs)			D.5 Gross Value of Electricity Used (in Lakhs)			D.6 Gross Wage Bill Paid- Contractual +permanent (in Lakhs)		D.7 Gross Value of Output (in Lakhs)			D.8 Gross Profit (in Lakhs)		
	2014-15	2013-14	2012-13	2014-15	2013-14	2012-13	2014-15	2012-13	2014-15	2013-14	2012-13	2014-15	2013-14	2012-13

E1: Coverage of Employees by type of health benefit (2013-14) [Ask for 2014-15 only if figures for 2013-14 are not available]									
E.1.1	Information provided for (Codes) (enterprise=1, some units together=2, one unit only=3)								
E.1.2	If answer for E.1.1=2, then for how many no. of Units the information will be provided (If information provided for some units together)								
Instruction: If answer for E.1.1= 1 or 2, fill question no. E.1.3=0 and If E.1.1=3 then copy the serial no. of units from Section-C									
E.1.3	Serial No. of Unit (Please add additional sheets if more than one units' information is provided separately)								
E.1.4	Expenditure Type	No. of employee covered							Total person covered including dependents
		Permanent		Contractual					
				>=1 Year		<1 Yr		No Written Contract	
		Eligibility Code	No. of employee	Eligibility Code	No. of employee	Eligibility Code	No. of employee	Eligibility Code	No. of employee
E.1.5	Employee State Insurance Scheme (ESIS)								
E.1.6	Other government funded social security scheme								
E.1.7	Private Voluntary or Group Insurance								
E.1.8	Reimbursement (Out Patient)								
E.1.9	Reimbursement (In Patient)								
E.1.10	Health awareness workshops/camps, etc. for employee only								
E.1.11	On-site doctor on call								
E.1.12	Dispensaries								
E.1.13	Hospitals								
E.1.14	Preventive programs								
E.1.15	Any Other (Specify)_____								

E2: Expenditure on Healthcare by Firms (2013-14)- ASK ACTUAL EXPENDITURE [Ask for 2014-15 only if figures for 2013-14 are not available]											
E.2.1	Information provided for (Codes) enterprise=1, some units together=2, one unit only=3)										
E.2.2	If answer for E.2.1=2, then for how many no. of Units the information will be provided (If information provided for some units together)										
Instruction: If answer for E.2.1= 1 or 2 fill question no. E.2.3=0 and If E.2.1=3 then copy the serial no. of units from Section-C											
E.2.3	Serial No. of Unit (Please add additional sheets if more than one units' information is provided)										
E.2.4 E.2.5 E.2.6	Expenditure Type	Permanent Employee		Type of Contract						All	
				>=1 year		<1 Yr		No Written Contract			
		(value)	Unit Code	(value)	Unit Code	(value)	Unit Code	(value)	Unit Code	(value)	Unit Code
E.2.7	Employee State Insurance Scheme (ESIS)										
E.2.8	Other government funded social security scheme										
E.2.9	Private Voluntary or Group Insurance										
E.2.10	Reimbursement (OP)										
E.2.11	Reimbursement (IP)										
E.2.12	Health awareness workshops/camps, etc. for employee only										
E.2.13	On-site doctor on call										
E.2.14	Dispensaries										
E2.15	Hospitals										
E2.16	Preventive programs										
E.2.17	Any Other (Specify- please refer E1.15)										
Unit code: Crore=1; Lakh=2; thousands=3											

***Eligibility Code**: Only Employee=1; Employee, spouse & dependent children =2; Employee, spouse & dependents=3; Any Other(specify)=4; None=5*

Skip Block E3 if no insurance (not coded in E2.9) provided by employer					
E3: Insurance Coverage					
E.3.1	Information provided for (Codes)				
	(enterprise=1, some units together=2, one unit only=3)				
E.3.2	If answer for E.3.1=2, then for how many no. of Units the information will be provided				
	(If information provided for some units together)				
Instruction: If answer for E.3.1= 1 or 2, fill question no. E.3.3=0 and If E.3.1=3 then copy the serial no. of units from Section-C					
E.3.3	**Serial No. of Unit (Please add additional sheets if more than one units' information is provided)**				
		Permanent	**Type of Contract**		
			>=1 year	<1 Yr	No Written Contract
Insurance Coverage by Types of Services *(Yes=1, No=2)*					
E.3.4	Ambulatory care				
E.3.5	Accidental/emergency case				
E.3.6	Hospitalization				
E.3.7	Post Hospitalization				
E.3.8	Maternity Benefit				
E.3.9	Any Other(Please Specify)_____				

E4: Expenditure on Corporate Social Responsibility (CSR)									
E.4.1	Do you spend on CSR? (Yes=1, No=2)								
Skip if answer for E.4.1=2	**E.4.2**		If yes, how much do you spend in total?			**Value**		**Unit code**	
	E.4.3		Do you spend on health (which does not include your employee)? (Yes=1, No=2)						
	Skip if answer for E.4.3=2	**E.4.4**	What is the amount you spend on health out of the total expenditure made on CSR?			**Value**		**Unit code**	**In % of total CSR**
		E.4.5	On what type of health services money has been spent?		**Type of care**	**Value**		**Unit code**	**In %**
				1	Ambulatory care				
				2	Accidental/ emergency case				
				3	Hospitalization				
				4	Post Hospital-ization				
				5	Maternity Benefit				
				6	Preventive care***				
				7	Any Other (Please Specify)				
		E.4.6	How is the money spent on health? (**Multiple Code Possible,** circle the options)		1	Own NGO/trust of company			
					2	Other NGO/trust			
					3	Government agency			
					4	Others (specify)			

***Eligibility Co**de: Only Employee=1; Employee, spouse & dependent children =2; Employee, spouse & dependents=3; Any*

E 5 Do you own a health facility of your own for e.g. dispensary/hospital etc.?	
Yes	1
No	2

Goto SECTION F only if coded 1 in above Else Thank & Terminate

F: Enterprises Owned Health Facilities (Ask only those Enterprise/ Unit who run their own health facility											
F1. Facility Serial No.	**F2.** Type of Facility ***(See Codes)***	**F3.** Ownership (**see Code**)	**F4.** No. of Beds	**F.5** Enterprise's Expenditure on Facilities				**F.6** Resource Generated from Facilities			
				2013-14		2014-15		2013-14		2014-15	
				Value	Unit code	Value	Unit code	Value	Unit code	Value	Unit code
1											
2											
3											

Type of Facility Code: *Dispensary with medical personnel other than doctor=1,Dispensary with generaldoctor=2,Dispensary/Clinic with specialists=3, General hospital=4, Multi-Specialty hospital=5, Single specialty hospital=6, diagnostic laboratory=7, ambulances =8, Others (specify)=9*

Ownership Code: *Sole ownership= 1, Partnership with government= 2, Partnership with other private sector= 3, Tied up with NGO/charitable unit= 4, trust hospital=5 Others (specify) = 9*

Unit code:*Crore=1; Lakh=2; thousands=3*

Thanks and terminate

A3. Survey on Health Expenditure by Non-Governmental Institutions Serving Households

Consent to participate in study

INTERVIEWER, PLEASE READ OUT: Namaskar, my name is *please say your name here*. I have come from the MART for collecting some information on behalf of Public Health Foundation of India (PHFI) to understand your Expenditure on Health at the NGO level. This will be very useful in preparing the National/State Health Account (NHA/SHA) for India. We will be asking you questions related to some basic information and health-expenditure related issues of your organization. We would appreciate your participation in this survey. The information collected would be kept confidential and anonymity of individual organization will be maintained. The information collected would be used only at the aggregate level of all the NGOs. The survey should take a short time (about 30-45 minutes) to complete. May I begin the interview now with your consent?

Oral consent given:			
	Yes →	Continue interview	
	No →	Stop interview	

Running sample NGO-ID:

S	L	T	Sr				

S: 2-digit state code, L: 1-digit location code, T: 1-digit code of NGO type, Sr: 4-digit serial number in sample list

A: Identification Particulars (to be filled by official of survey agency)							
A.11	Name of NGO (official/registered name)						
A.12	State where NGO is located	Name:				Code:	
A.13	Serial number in NGO-sample list						
A.14	Location of main/head office of NGO (use code: Rural = 1, Urban = 2)						
A.15	Type of NGO (use code: Large primary health-NGO = 1, Primary health-NGO = 2, Subsidiary health-NGO = 3, Non-health-NGO = 4)						
A.16	Starting and ending dates of interview	Starting date (DD:MM:YYYY)	DD:	MM:	YYYY:		
		Ending date (DD:MM:YYYY)	DD:	MM:	YYYY:		
A.17	Name of the interviewer						

B.1: Basic Information of NGO				
B.1.1	Address of the NGO			
	District name & Pin code			
	Phone/Mobile number			
	Email ID & Web (*if any*)			
B.1.2	Name of the key informant			
B.1.3	Designation of the key informant			
B1.4	Registration status (use code: Yes=1, No = 2) ***Multiple options possible***	Society registration act (including its state variant)		
		Public/private trust act		
		Religious trust/endowment act		
		Indian charitable act		
		Wakf act		
		Section 8 or 25 of company act		
		Others(specify)_____		
B1.5	Year of registration and start of functioning	Registration:		Functioning:
B1.6	Location of operation (use code: Rural=1, Urban=2, Both=3)			
B1.7	Primary activity in terms of annual financial flow (Health =1, Non-health =2)			
B1.8	Two most important subsidiary activities, if any (use codes)	First important		
		Second important		
B1.9	Primary activity in terms of time devoted annually (Health =1, Non-health =2)			
B1.10	Details of HEALTH activity (use code: Yes=1; No=2) ***Multiple options possible***	1	Medical college (maintained by trust)	
		2	Hospital	
		3	Clinic for rehabilitative and long-term care	
		4	Clinic or dispensary for outpatient care	
		5	Clinic for ancillary services like lab and/or image tests, ambulance	
		6	Non-clinical medical support like management/financial help	
		7	Health insurance scheme for community or targeted group	
		8	Outreach for health benefits of community	
		9	Research in medical and/or public health	
		10	Others-A specify)_____	
		11	Others-B specify)_____	
B1.11	As per the above list of **HEALTH** activities, which is main activity (use serial no. from B.1.10)			
B1.12	Units currently functioning in India	Within the state		Outside the state
B1.13	Accounting status in 2013-14 (use code: Audited a/c = 1, Unaudited a/c = 2, No a/c available= 3)			

Code for B.1.8 (*subsidiary activity*): Health = 1, Education & Research = 2, Culture & Recreation = 3, Social (non-health) Services = 4, Environmental Services = 5, Housing & Development = 6, Law/Advocacy & Politics = 7, Business/ Professional Association = 8, International Activities = 9, Philanthropic & Voluntary = 10, Religious Activity = 11, Others = 12 [specify here]_____ Not applicable = 99.

If code for question B.1.10–8=2 *(i.e. no outreach activity by NGO),* ***skip block B.2 below & go to C***

B.2: Details about outreach activity related to health (use code: Yes=1, No=2)

B.2.1 Awareness campaigns, enrolment drives, etc.

B.2.2 Health camps for surgical procedures

B.2.3 Health camps for diagnostics and general check-up of community/targeted groups

B.2.4 Child immunisation programmes

B.2.5 Blood Donation Camp

B.2.6 Antenatal and/or postnatal care of women (ANC/PNC)

B.2.7 Others-A (specify) _____

B.2.8 Others-B (specify) _____

B.2.9 Others-C (specify) _____

C: Geographical Spread of NGO across India **Put State Code = 100, if information is provided for all states together *(only when can't get state wise break up)***					
State Code [use respective state code from instruction manual]		Number of Employees, of which			
		Regular	Part-time	Volunteers	Total
C.1		C.2	C.3	C.4	C.5

D.1: Aggregate Receipts		
Receipts	**Amount in Rs. Lakh**	
	2013-14	**2014-15**
D.1.1	D.1.2	D.1.3
Health Grants		
Non-Health Grants		
Receipts other than grants		
3.1) Public donation and Membership fees		
3.2) Sale of assets/products		
3.3) Own resources like rent, interest, etc.		
3.4) Others (specify) _____		
Total Receipts		

D.2: Details about Receipts (Health Grants)											
Grant Serial No.	Name of the Grant	Source of Fund	Purpose (use code, **multiple codes possible**)				Total Value of the Grant (**in Rs. Lakh**)	Time period		Amount of Receipts (**in Rs. Lakh**)	
								Initial Year	Terminal Year	2013-14	2014-15
D.2.1	D.2.2	D.2.3	D.2.4	D.2.5	D.2.6	D.2.7	D.2.8	D.2.9	D.2.10	D.2.11	D.2.12
1											
2											
3											
4											
7											
8											
9											
10											
11											
12											
100	Total Health Grant										

Code for D.2.3 (Source of Fund): Central Government=1; State Government=2; Local Government=3; Foreign Funder=4; Private Organisation/Corporate=5; CSR fund=6; Other-NGOs=7; Others=8 (specify) _____

Code for D.2.4-7 (Purpose of the Fund): HIV/AIDS=1, Reproductive, Maternal and Child Health=2, Adolescents=3, Tribal health=4, Disabled=5, Malaria, dengue, etc. =6, TB control=7, Health system management/monitoring=8, Child Blindness=9; Others (specify)=10 _____

E.1: Details about Expenditure		
Expenditure Details	Amount of Expenditure (in Rs. Lakh)	
	2013-14	2014-15
E.1.1	E.1.2	E.1.3
1. Medical college (maintained by trust)		
2. Hospital		
3. Clinic for rehabilitative and long-term care		
4. Clinic or dispensary for outpatient care		
5. Clinic for ancillary services like lab and/or image tests, ambulance		
6. Non-clinical medical support like management/financial help		
7. Health insurance scheme for community or targeted group		
8. Awareness campaigns, enrolment drives etc.		
9. Health camps for surgical procedures		
10. Health camps for diagnostics and general check-up of community/targeted groups		
11. Child immunisation programmes		
12. Antenatal and/or postnatal care of women (ANC/PNC)		
13. Blood Donation camps		
14. Research in medical and/or public health		
15. Other Expenditure on Health (specify) _____		
16. Expenditure on **NON-HEALTH** activities		
Total Expenditure of NGO		

E.2: Disaggregated Expenditure on Health (in Rs. Lakh)				
Head of expenditure			2013-14	2014-15
E.2.1			E.2.2	E.2.3
Total HEALTH expenditure				
	Of which	Salary of medical officers (DOCTORS)		
		Salary of paramedics/nurses		
		Salary of other health personal		
		Medicines		
		Equipment		
		Other medical consumables (specify) _____		
		Maintenance costs		
		Other medical expenses like administrative costs		
		Health awareness of community (camp, poster, loudspeaker, etc.)		
		Others (specify) _____		
	Grant/aid to others organisations/NGOs for their health activity			
	Health benefits for own employees of NGO			

E.3: Coverage of Health Benefit to OWN EMPLOYEES (2013-14)							
Expenditure type	Regular		Part time		Volunteers		Total Expenditure (in Rs. Lakh)
	Eligibility code	No. of employees	Eligibility code	No. of employees	Eligibility Code	No. of employees	
Government funded social security schemes							
Private Voluntary or Group Insurance							
Reimbursement for outpatient care to employee							
Reimbursement for inpatient care to employee							
On-site doctor on call for employee							
Preventive healthcare programs for employee							
Any Other (specify) _____							

Eligibility Code: Only Employee=1; Employee, spouse and dependent children =2; Employee, spouse and all other dependents=3; Any Other =4(specify) _____, Not applicable=99.

F.1 Is there any health facility run by the NGO (Yes=1, No=2) _____

Terminate the interview if F.1=2

F.2: Details about Own Health Facility of NGO						
F.2.1	F.2.2	F.2.3	F.2.4	F.2.5	F.2.6	F.2.7
Facility serial number	State (use state code)	Type of facility (use code)	Ownership of facility (use code)	Number of general beds	Number Medical Officers (Doctors)	No. of Nurses & Other Medical Staff
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Code for F.2.3 (facility type): Clinic/dispensary with paramedics/nurses (other than doctor) =1, Clinic/dispensary with general doctor=2, Clinic/dispensary with specialists=3, General hospital=4, Multi-specialty hospital=5, Single specialty hospital=6, Lab/image testing center only =7, Others = 8 (*specify*) _____.

Code for F.2.4 (ownership): Sole ownership= 1, Partnership with government= 2, Partnership with other private sector= 3, Tied up with other NGOs/charitable trusts=4, Others=5 (specify here) _____.

F.3: Details about Patient Load in own Health Facility of NGO																
F.3.1	F.3.2	F.3.3	F.3.4	F.3.5	F.3.6	F.3.7	F.3.8	F.3.9	F.3.10	F.3.11	F.3.12	F.3.13	F.3.14	F.3.15	F.3.16	F.3.17
Facility serial number	State	Number of OUTPATIENTS treated					Number of INPATIENTS treated					Number of Emergency				
	(use state code)	Last week	Last month	2013-14	2014-15	2015-till date	Last week	Last month	2013-14	2014-15	2015-till date	Last week	Last month	2013-14	2014-15	2015-till date
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																

Ministry of Health & Family Welfare
Government of India