

PART II
Chapter 9

**Classification of Factors
of Health Care Provision
(ICHA-FP)**

Introduction

Knowing how much health providers spend on the inputs needed to produce health care goods and services (factors of provision)¹ can have many policy uses. This information is typically tracked at national aggregate levels to meet the need to ensure an efficient, appropriate allocation of resources in the production of health care services. Specific policy needs may require information regarding total payments for human resources, expenditure on pharmaceuticals, and other significant inputs. Furthermore, the financial planning of health programmes and services often relies on information about the volume and mixture of factor spending.

Key to this chapter is the grouping together of variables so as to offer a global insight into the factors of provision used by health care providers, as these represent the valued inputs used in health care delivery for the resident population. Thus, factors of provision are to be determined by all the domestic providers in the system. The total of the distribution of expenditure by factors of provision is expected to equal the current expenditure on health. Clearly, for operational reasons, imported services are not disaggregated by factor, but, as far as possible, the inputs used for exported services should be excluded.

The classification of factors of provision was not identified as an explicit item in SHA 1.0. However, for the internal estimation process, separate accounts for both non-market and market production were recommended as an essential tool (SHA 1.0: 5.21). Such estimations for cost data are essential. The *Producers Guide* (PG) proposed a classification of resource costs based on the Government Finance Statistics Manual.² The factors of health care provision (FP) classification presented here is a revised version of the PG resource cost classification. Explanatory notes on selected factors and provision units are also included.

In terms of data sources, most government reports include audited values with a “line item” approach frequently found for the governmental sector of the health system. A classification of factors is also part of other public reporting systems, and it is a standard tool of analysis for government finance statistics at the international level.³ For private providers, enterprises also have certain obligations to report costs for internal accounting purposes. A factors of provision classification is also needed for reports to the tax authorities (*e.g.* in the case of VAT and income tax). Thus, to develop more comprehensive health care accounts some countries might consider the implementation of FP.

Main concept

The scope of the factor classification

Factors of provision are defined in SHA as the valued inputs⁴ used in the process of provision of health care.⁵ The boundary of health care (as set out in Chapter 4) determines the boundary of health care provision and by implication the factors of provision by provider. Provision involves a mix of factors of production – labour, capital and materials and external

services – to provide health care goods and services. It refers not only to health-specific resources but also to the non-health specific inputs needed to generate health services, all of them equally important for efficiency purposes. Some examples are:

- Labour involved in health care, security, maintenance and other services;
- Capital consumed, including buildings and medical and office equipment;
- Medical materials such as sutures and syringes, as well as non-medical inputs such as electricity, water and cleaning supplies;
- Externally purchased services, which may include laboratory services, legal services and any outsourced support services, such as food preparation for patients, cleaning and security or garden services, administration and so on.

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 health care provision account for the total value of the resources, in cash or in kind, used in the provision of health care goods and services. It is equal to the amount payable to health care providers by the financing schemes for health care 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. The spending for capital to be used in the provision of future periods should be separated from the use of resources for the current provision of health care, as in the other ICHA classifications.

Factors of provision can be cross-classified with different axes to illustrate the shares of current health expenditure allocated to resources of labour, pharmaceutical supplies, use of equipment and buildings, and so on. For example, the cross-classifications can show providers by factors of provision (HPxFP), where the focus is more on differences across production patterns (providers).

If the financing axes are cross-classified with the factors of provision (FS/HFxFP), the data facilitate an assessment of how different financing and allocation strategies affect mixes of “inputs” (see PG 5.20). The factors of provision can be purchased through various revenue sources and means for each provider, which makes it relevant to identify the various funding strategies to cope with financing needs.

The table of factors of provision by function (HCxFP) allows a measurement by production factor mix according to the purpose of consumption (Table 9.1). The profile of inputs is frequently used to monitor and plan scaling-up processes by type of service.

Notes related to the classification and selected types of classes

The boundary of Factors of health care provision

Health care providers deliver not only health care but also some products that are outside the health care boundary. For ICHA classifications, the goal is to identify and restrict the core component of all classifications to the health care boundary. This is also the case for the classification of factors of provision, which thus has the aim of assigning all types of resources to health care activities. The inputs used to provide activities outside the health care boundary, for example, cosmetic surgery or social services, or any exported health services, should – as far as possible – be separated and reported below the line if this is of interest for national policy analysis. These could be displayed as Factor of Provision-related components.

Table 9.1. **Classification of factors of health care provision**

Code	Description
FP.1	Compensation of employees
FP.1.1	Wages and salaries
FP.1.2	Social contributions
FP.1.3	All other costs related to employees
FP.2.	Self-employed professional remuneration
FP.3	Materials and services used
FP.3.1	Health care services
FP.3.2	Health care goods
FP.3.2.1	Pharmaceuticals
FP.3.2.2	Other health care goods
FP.3.3	Non-health care services
FP.3.4	Non-health care goods
FP.4	Consumption of fixed capital
FP.5	Other items of spending on inputs
FP.5.1	Taxes
FP.5.2	Other items of spending

Source: IHAT for SHA 2011.

There may be clear differences in the structure of factors of provision between market and non-market production (for example, the remuneration of human resources can differ for public and private health providers). This information can also be displayed if there is a national interest in analysing it in detail.

Households as providers

An important starting point is that the totality of spending on the factors of provision is equal to the amount spent on the consumption of health care goods and services for each provider category. Furthermore, to be included within the health care boundary, a transaction is required: in principle, only payments linked to health care provision should be included. Households (HP 8.1) mostly provide health care for own consumption. Within the health care boundary, this provision is included only when a transaction is documented, *e.g.* when some compensatory payment for LTC services and/or when reimbursement for in-kind provision is received. These transactions should be accounted for explicitly to facilitate a matching of totals with the financing axis. Transactions on inputs linked to own consumption normally have no accounting records. If it is important for national policy reasons to account for the inputs used for own-produced health care services, it is recommended to report them as memorandum items. To do that, the majority of these factors may need to be imputed.

Providers of governance and administration of health care financing

The providers of administration of health financing (HP.7) also require special treatment. The category of administrators of health financing schemes, notably health insurance, is often a category that consists of providers of health care services as a secondary activity. This can be the case for both government as well as private organisations engaged in activities related to the management of health insurance. The planning, management, regulation and collection of funds and the handling of delivery system claims are performed not only for the private health system but also for other (non-health-related) insurance packages. The health share within the total output of

institutions such as insurance companies can be very small, as could the use of inputs for the provision of these services. For example, social security can have total costs covering more than just the operation of the health insurance funds. In some countries this can represent a minor component, but in other countries it can be the largest. This is also the case in private insurance companies, which operate much more than health care insurance.

Governance of health care services is clearly a primary activity of government ministries of health and agencies with a major role in the health system. The units involved in governance and administration are primarily engaged in formulating policy, co-ordinating and monitoring plans, programmes and budgets, and administering, operating and supporting the social security funds that cover the health services. They are involved as well in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics and so on. This includes the regulation and licensing of providers of health services. The sum of factors of provision involved in governance and administration should equal the total expenditure amount presented in the provider classification category on administration (HP.7).

Explanatory notes to the ICHA-FP classification of factors of health care provision

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 includes wages and salaries and all forms of social benefits, payments for overtime or night work, bonuses, allowances, as well as the value of in-kind payments such as the provision of uniforms for medical staff.

The compensation of employees measures the remuneration of all persons employed by providers of health care irrespective of whether they are health professionals or not.⁶

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

When shareholders also work for the corporation and receive paid remuneration other than dividends, the shareholders are treated as employees. The owners of any type of corporations who work in that corporation and receive paid remuneration other than the withdrawal of earnings from the corporation are also treated as employees.

Students who contribute their labour as an input into an enterprise's process of production, for example, as worker trainees, student nurses and hospital interns, are treated as employees, whether or not they receive any remuneration in cash for the work they do in addition to the training received as in-kind payment.

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, and in-kind provision of goods and services required to carry out the work or as meals and drinks, uniforms⁷ and

transportation. It excludes social security paid by the employer. Social contributions paid on behalf of employees are the actual or imputed payments to social schemes to secure their entitlement to social benefits such as social security.

FP.1.2 Social contributions (see SNA 2008 7.56 for more detail)

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/insurance on behalf of the employees (as well as contributions for pensions).

As employers' social contributions are made for the benefit of their employees, their value is recorded as one of the components of compensation of employees. The social contributions are then recorded as being paid by employees as current transfers to the social security schemes or other employment-related social insurance schemes.

FP.1.3 All other costs related to employees

Retention policies have been developed in many countries to ensure service delivery by health personnel under hardship conditions. These conditions can vary with social situations, geography and disease conditions, such as communicable diseases like HIV/AIDS, and with extreme weather conditions, low salaries, etc. Specific incentives in monetary terms and in kind can be recorded here.

Fringe benefits are also to be recorded here, such as the provision of a car to employees,⁸ or the provision of benefits so that the employee obtains a car with a major discount.

FP.2 Self-employed professional remuneration⁹

The class FP.2 is meant to be used for independent self-employed professionals carrying out health care activities. This class refers to the remuneration of the independent health professional practice, to the income of non-salaried self-employed professionals and to the complementary or additional income generated through the independent practice of salaried health personnel, which is common in most countries' health systems. Despite the frequency, relevance and importance of the work performed by qualified independent practitioners in health care, full measurement standards have not been proposed and reached in most guides. Measurement has been approached through surveys and through records from providers, notably related to the SNA. In fact, this type of income is involved in all practitioners' offices¹⁰ and quasi-corporations.

Self-employed income refers to final consumption payments made by patients or health care beneficiaries to independent professionals. The income resulting from the operation of an independent medical practice usually refers to the sole owners or to the joint owners of the organisations in which they work. It includes the remuneration for work performed by the health care professional (and other household members, if applicable) and their profit as the owner or entrepreneur. The income of households, as providers of paid long-term care, is recorded as mixed income under FP.2 after deduction of the cost of delivering home care.

The income of non-salaried self-employed health professionals is the remuneration for their work 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.

Frequently the remaining income cannot be identified separately from the profits earned as the owner or entrepreneur. In many cases, though, the element of remuneration may dominate the value of the total income.¹¹ In national accounts it is estimated as a residual or “balancing item”.¹² Profits/losses exist after deduction of capital costs but before income taxes.

In case the household is treated as a quasi-corporation and provides a complete set of accounts, the income component of the owner can be separated from the profits earned as entrepreneur and is to be classified as compensation of employees. The remaining balance (total earnings minus total cost) is in this case treated as gross operating surplus, as would be the case in corporations.

The acquisition of supplies (FP.3) and capital consumption (FP.4) should not be included, neither the cost of capital (financial and non-financial). The cost of financial capital is recorded under the item FP.5.2: other items of spending on inputs.

FP.3 Materials and services used

This category consists of the total value of goods and services used for the provision of health care goods and services (not produced in-house) bought in from other providers and other industries of the economy.¹³ All the materials and services are to be fully consumed during the production activity period.

Materials refer to all the health care and non-health care 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.

Services used involve the purchase of services produced by another agent. They can be defined as outsourced or external services purchased by the provider and involved in their own production process. 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. They can also include health care services such as laboratory work, imaging and patient transportation.

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 Health care services

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

Health care services purchased by a provider to complement the package of services offered by that health provider can be offered within the same unit or in a different one. The purchased service can imply the movement of the patient to the other unit where the purchased service is provided, such as when the patient is taken to another hospital or unit

to get a specialised treatment or test, as in the case of imaging services. Another example is when services are moved between provider locations, such as when test interpretations and imaging results are delivered through electronic means from other units. These movements can involve samples for laboratory tests that are actually developed and interpreted in another unit. It can also imply that the provider of the service is moving to the patient's location (see Box 9.1 for more details on intermediate consumption).

FP.3.2.1 Expenditure on pharmaceuticals and FP.3.2.2 Other health care goods

Pharmaceuticals are defined as any chemical compound used in the diagnosis, treatment or prevention of a disease or other abnormal condition. They include reactive and other chemical products used in laboratory tests.¹⁴

The share of pharmaceuticals and other medical goods in total health use is one topic of particular interest to policy makers. Medicines and medical goods, together with human resources, represent at least two-thirds of current spending in most health systems. No standard measurement has been set in many countries. This expenditure item¹⁵ is partially covered by the functional classification, with a display for medical goods independently consumed (HC.5.1 in SHA 1.0 and SHA 2011) and for inpatient consumption, not separately described but contained in the service provision (the same is possible in day-care services and in outpatient care too). In the factors of provision classification, this item is expected to cover the totality of use of medicines and other medical goods, regardless of their mode of provision. Thus, services supplied to hospital patients using medicaments, prostheses, medical appliances and equipment and other health-related products should also be detailed here.

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. An example is medicines or supplies for the treatment of cancer or HIV/AIDS, such as antiretroviral medicines.

- *Includes:* all medicines and pharmaceutical products such as vaccines and serum and other 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).
- *Excludes:* all goods acquired to increase stocks should not be included, such as medicines to be stored for future use. Excluded are also equipment and tools to be repeatedly used, which are part of capital.

FP.3.3 Non-health care services and FP.3.4 Non-health care goods

These classes involve goods and services used for health care production, but of a non-specialised health nature. They are of a general nature such as those required in the operational activities of the provider, as in management offices (*e.g.* software, pens and paper), kitchens (in hospitals and to supply to overnight patients if they are not outsourced services), transport (*e.g.* oil and tools to operate vehicles) or other types of more general usage, such as electricity, water and the like.

Some countries may want to have a more detailed classification of these non-health care materials and services, *e.g.* for the calculation of multi-factor productivity (*e.g.* KLEMS

Table 9.2. **Further breakdown of non-health care goods**

Code	Description
FP.3.4	Non-health care goods
FP.3.4.1	Energy
FP.3.4.2	Water
FP.3.4.3	All other non-health care goods

Source: IHAT for SHA 2011.

multi-factor measurement: capital, labour and inputs (see also Box 9.1) of energy, supplies and services). In that case, additional codes could be introduced in FP.3.4, at the third-digit level as presented in Table 9.2 below.

In SNA 2008 and the *Eurostat Manual of Supply, Use and Input-Output Tables* (Eurostat, 2008c) both electricity as a component of energy products and water are treated as goods. This is the convention followed in this Manual.

Non-health care services such as services for infrastructure are also required (e.g. maintenance of buildings and equipment). Typically, 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.

Maintenance is one of the services that is frequently of interest. The distinction between maintenance and repairs and gross fixed capital formation (see Chapter 11) is not clear-cut. The ordinary, regular maintenance and repair of a fixed asset used in production constitutes a normal cost item and is recorded under material and services used. Ordinary maintenance and repair, including the replacement of defective parts, are typical activities provided in-house, but such services may also be purchased from other enterprises. Whether these maintenance and repair services are provided in-house or purchased from other enterprises, they should be included as factor costs. However, the valuation in both cases is different, depending on the way charges are made:

- In-house maintenance would allow a separate bill for human resources (under FP.1) and any materials used (e.g. FP.3.4);
- Outsourced maintenance usually gets a full bill, including both factors.

The practical problem is to distinguish ordinary maintenance and repairs from major renovations, reconstructions or enlargements that go considerably beyond what is required simply to keep the fixed assets in good working order. Major renovations, reconstructions or enlargements of existing fixed assets may enhance their efficiency or capacity or prolong their expected working lives. They must therefore be treated as gross fixed capital formation, as they add to the stock of fixed assets in existence.

Ordinary maintenance and repairs are distinguished by two features:

- They are activities that owners or users of fixed assets are obliged to undertake periodically in order to be able to utilise such assets over their expected service lives. They are current costs that cannot be avoided if the fixed assets are to continue to be used. The owner or user cannot afford to neglect maintenance and repairs, as the expected service life may be drastically shortened otherwise;
- Maintenance and repairs do not change the fixed asset or its performance, but simply maintain it in good working order or restore it to its previous condition in the event of a

breakdown. Defective parts are replaced by new parts of the same kind without changing the basic nature of the fixed asset.

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 (see SNA 2008, 6.244). 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.¹⁶ The consumption of fixed capital should reflect underlying capital use as a factor of production at the time the production takes place. For further details see Chapter 11 "Capital formation in health systems".

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, and fees, commissions, royalties, etc., payable under licensing arrangements. These are included as the purchase of services. In theory the benefits of the use of own capital¹⁷ should be considered. This estimate would require difficult imputations that are not justified due to the relatively low values involved.

FP.5 Other items of spending on inputs

This item includes all the financial costs, such as interest payments on loans, taxes and so on.

FP.5.1 Taxes¹⁸

Following the definition of the SNA, 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. The item FP.5.1: Taxes in the factor cost account comprise taxes on production and taxes on products. As the name implies, taxes on products are payable per unit of the product. The tax may be a flat amount that depends on the physical quantity of the product or it may be a percentage of the value at which the product is sold, *e.g.* VAT. Taxes on production are taxes imposed on the producer that are neither applied to products nor levied on the producer's profits. Examples include taxes on the land or premises used in production or on the labour force employed.

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.

Interest payments accruing to loans made by different entities are not negligible. Interest is defined as payment on top of the amount of the principal borrowed that has to be paid to the creditor by the debtor over a given period of time and that does not reduce

Box 9.1. Relevant facts related to intermediate consumption in the health system

Intermediate consumption in the macroeconomic accounts of the SNA relates to the interaction between the analysed branch (in this case health care) and the rest of the economy, and consists of the goods and services used up in the course of production in that branch (health care goods and services). Several issues need to be considered when the concept of intermediate consumption is applied to a functional health approach, which aims to comprehensively account for and analyse expenditure for the health purpose. Below are some of the main features of intermediate consumption:

- ❖ Health care goods and services can be provided by a range of establishments whose primary activity is not necessarily the production of health care services. In macroeconomic accounting, occupational health care, i.e. the provision of health services to employees by an enterprise, which leads to its economic benefit, is recorded as intermediate consumption. It is thus not recorded as a health product except when a detailed record is made, as in a supply and use table. From a health accounts point of view, all resources used with a direct health purpose should be included, and in this case, health care offered to employees as beneficiaries involves the consumption of these services. Many other services obtained from secondary providers involve health consumption by households.
- ❖ When in the macroeconomic accounts an activity is allocated to a branch, there is no loss for the measurement of the total economy, but for health accounts some functions may be relatively undervalued and some others overvalued. Some health services are linked to business requirements, such as eye tests and blood alcohol tests for airline pilots. Current recording procedures do not permit a fine reallocation of the few services that essentially benefit the enterprise and are of limited benefit to households. On the basis of general accounting principles, a complete allocation of these services to household consumption is needed.
- ❖ Some health needs are satisfied by a bundling of inpatient and outpatient services, such as diagnostic procedures (laboratory and imaging) and the prescription/provision of medical goods. Two situations may arise with respect to intermediate consumption:
 - Health services are consumed as part of a “package”, produced and provided in a single health contact to the patient in a health establishment. Any typical case-mix in services involves resources of one establishment, which are included both in the production and in the costing schedule. Production value and final consumption value match one another. The value of final consumption equals the sum of the value of the inputs used, which equals the value of the goods and services consumed. For all providers, the remunerations of employees are included. For market services, entrepreneurial income is added to that value. The total value is already supplied in the commodity’s bill.
 - When an establishment outsources part of the service, for example, some ancillary services are purchased from another establishment, domestic or foreign, the total value of the final use is reflected in the bill, but they are reflected in an aggregate of intermediate services purchased. A risk of double-counting exists as well as a risk of omission, depending on the data sources used in the establishment, and according to the way accounts are generated.

Box 9.1. Relevant facts related to intermediate consumption in the health system (cont.)

- ❖ Within the health system, a considerable amount of intermediate consumption is generated in the total product consumed by households. Hospital billing not only includes the services provided by the hospital itself but may also include purchases from the pharmaceutical industry, transport industry, food industry and so on. The intermediate purchases need to be distinguished¹⁹ because they are included in the final consumption expenditure, but they may not be disaggregated on the production side. This fact could potentially undervalue health production compared to other branches of the economy.

the amount outstanding. Interest may be a predetermined sum of money or a percentage of the outstanding principal. Interest is added to the principal. When government units pay interest on debts on behalf of another unit, as the government incurring the debt as the primary obligor (debtor), the interest paid on the existing debt of another unit should be recorded as a subsidy (when the other unit is an enterprise) or a transfer (if it is a government unit).

Cross-classification of functional and economic classifications of expenses (GFSM)

Table 9.3 cross-classifies the economic and functional classifications of expenses. The table includes a column for acquisitions of non-financial assets, in addition to columns for each type of expense. The table is relevant for reporting the expenses of financing schemes (see Chapter 7).

Table 9.3. Cross-classification of functional and economic classifications of expenses

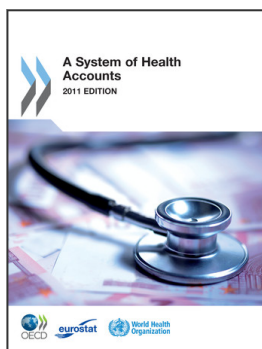
	Compensation of employees [GFS]	Use of goods and services	Consumption of fixed capital [GFS]	Interest [GFS]	Subsidies	Grants	Social benefits [GFS]	Other expense	Acquisition of non-financial assets
General public services									
Defense									
Public order and safety									
Economic affairs									
Environmental protection									
Housing and community amenities									
Health									
Recreation, culture, and religion									
Education									
Social protection									

Source: IMF (2001), Table 6.3, p. 78.

Notes

1. Factors of provision are all the inputs used in the process of producing health care goods and services. In national accounts terminology, part of the factors of provision are treated as value added components (e.g. compensation of employees), while another part is treated as intermediate consumption (e.g. materials and services used).
2. See for example Providers Guide, Table 4.8, p. 47, and IMF (2001), Table 6.1, p. 63.
3. Table 6.3 of the GFSM cross-classifies the economic and functional classifications of expenses. The table includes a column for acquisitions of non-financial assets in addition to columns for each type of expense. The table is relevant for reporting the expenses of financing schemes (see Chapter 7).
4. Included in the FP classes are taxes. Although, technically speaking, taxes are not an input, they represent an important factor in expenditure.
5. Factors of provision spending in SHA are the uses of the providers and are presented on the left-hand side of the T-account, which on the right-hand side shows the revenues (payments by financing schemes).
6. In order to be classified as employed, that is, either as an employee or self-employed, the person must be engaged in an activity that falls within the production of health care provision. Non-employed persons consist of the unemployed and persons not in the labour force (SNA 2008, 7.29). Employees are workers in a relationship with an employer: this involves a written or oral agreement, formal or informal, between an enterprise and a person, normally entered into voluntarily by both parties, whereby the person works for the enterprise in return for remuneration in cash or in kind. The remuneration is normally based directly, or indirectly, on the amount of work done, on either the time spent at work or labour contributed to some process of production, or some other objective indicator of the amount of work done, and is paid at a previously agreed fixed amount. The self-employed are persons who work for themselves and whose self-owned enterprises are distinguished neither as separate legal entities nor as separate institutional units in the SNA. They may be persons who are the sole owners, or joint owners, of the unincorporated enterprises in which they work or a member of a producers' co-operative or a contributing family worker (that is, a family member who works in an unincorporated enterprise without pay). The self-employed are remunerated as a function of the value of the outputs from some process of production for which that person is responsible, regardless of how much is contributed to it.
7. Uniforms provided by the employer are part of intermediate consumption. According to SNA 2008, "when the goods or services are used by employees in their own time and at their own discretion for the direct satisfaction of their needs or wants, they constitute remuneration in kind. However, when employees are obliged to use the goods or services in order to enable them to carry out their work, they constitute intermediate consumption" (SNA 2008, 6.220). The latter is generally the situation for health workers.
8. Although fringe benefits should be included, valuing them can sometimes be problematic. The valuation of a car or the use of a car could be easy, but other things such as the use of a mobile phone could be more difficult. It could also mean that benefits have to be estimated when they are covered in a government budget under an item such as housing, for instance if employees are living in a house for free. This is frequently the case of health personnel located in rural areas.
9. 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.
10. In national accounts, when households engage in production they can be treated like corporations. Household "unincorporated" market enterprises are created for the purpose of producing goods or services for sale or barter on the market as a small enterprise. They can be engaged in virtually any kind of productive activity, including health care services. They can range from single persons working in health care with virtually no capital or premises of their own up to e.g. large specialist practices with employees (derived from SNA 2008, 4.155). Private practices in health care that have employees are treated as corporations and include a type of salaried employees (even the owner can keep a salary from his enterprise). Non-salaried private practices involve small enterprises with self-employed workers, represented in national accounts within the household sector. See HP classification. An unincorporated corporation can be treated as a quasi-corporation also when it refers to a small enterprise but it has a complete set of accounts.

11. Operating surplus and mixed income are two alternative names for the same balancing item used for different types of enterprises in the SNA. Mixed income is the term reserved for the balancing item of the generation of income account of so-called unincorporated enterprises owned by members of households. For example, private practitioners as providers of paid long-term care are unincorporated organisations, and their balancing item after the deduction of the cost of delivering health care would be recorded as mixed income FP.2 in the factors of provision account.
12. In the SNA, this terminology refers to the net operating surplus, which measures the surplus or deficit accruing from production after taking account of any interest, rent or similar charges payable on financial or tangible non-produced assets borrowed or rented by the enterprise, or any interest, rent or similar receipts receivable on financial or tangible non-produced assets owned by the enterprise. That is to say, excluding operation and capital costs.
13. This class is comparable to “intermediate consumption”. Following the SNA, intermediate consumption consists of the value of the goods and services consumed as inputs by a process of production, excluding fixed assets, as costs associated with these are recorded in the consumption of fixed capital (an imputed cost). The goods or services may be either transformed or used up by the production process.
14. See Chapter 5 for a full description of the content of the category pharmaceuticals.
15. The expenditure on medical goods for outpatient services and the expenditure on medical goods for inpatient services together are presented as total spending on medical goods in the functional classification only as a memorandum item. In theory, the value of the medical goods used in the production process of health provision (FP) should equal the purchasing value of these goods by the providers.
16. For the European Union countries, on average approximately one-third of the output of the health branch is absorbed as input in the production of other health services (*i.e.* as intermediate consumption) by the health branch itself (*Source:* Eurostat website SUT data for 2000, extracted on 9 March 2011).
17. The consumption of fixed capital is the economic value of the use of capital goods in the production used by national accounts. In business accounts, the term depreciation is used, which usually reflects the legally allowed amounts of the capital goods to be included in the cost structure of the companies.
18. There might be national regulations concerning the reimbursement of services by public agencies, in which case it would be difficult to exclude this component. In such cases the remuneration of the use of capital is included in the factors of provision.
19. Taxes in essence are not a resource but paid from revenues. Taxes are part of the cost structure of the provider and as such are of interest in the expenditure.



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