

Input Document Unit 9 & 10

Input paper for the classifications of the Financing Sources and Financing Agents/Schemes

Summary

Many policy concerns are associated with a public/private split in funding on the sources level specifically which should be reflected in international reporting. This input paper for Units 9 and 10 brings forward arguments for a more distinct and useful split in public and private sources compared to the current SHA 1.0, based on whether a contribution is compulsory or voluntary. External funding is very difficult to track with available standards and methods. SHA 2.0 should provide clear guidance on how to capture this. The basic structure of the proposed Financing Schemes presented at the OECD health accountants meeting in October 9-10 is useful and provides a good basis for the new SHA. But some definitions have to be changed and some of the categories are not needed. An NGO category is proposed as a solution to the problematic NPISH category.

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 Submitted on 26/01/2009
 Document code 09002

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Introduction

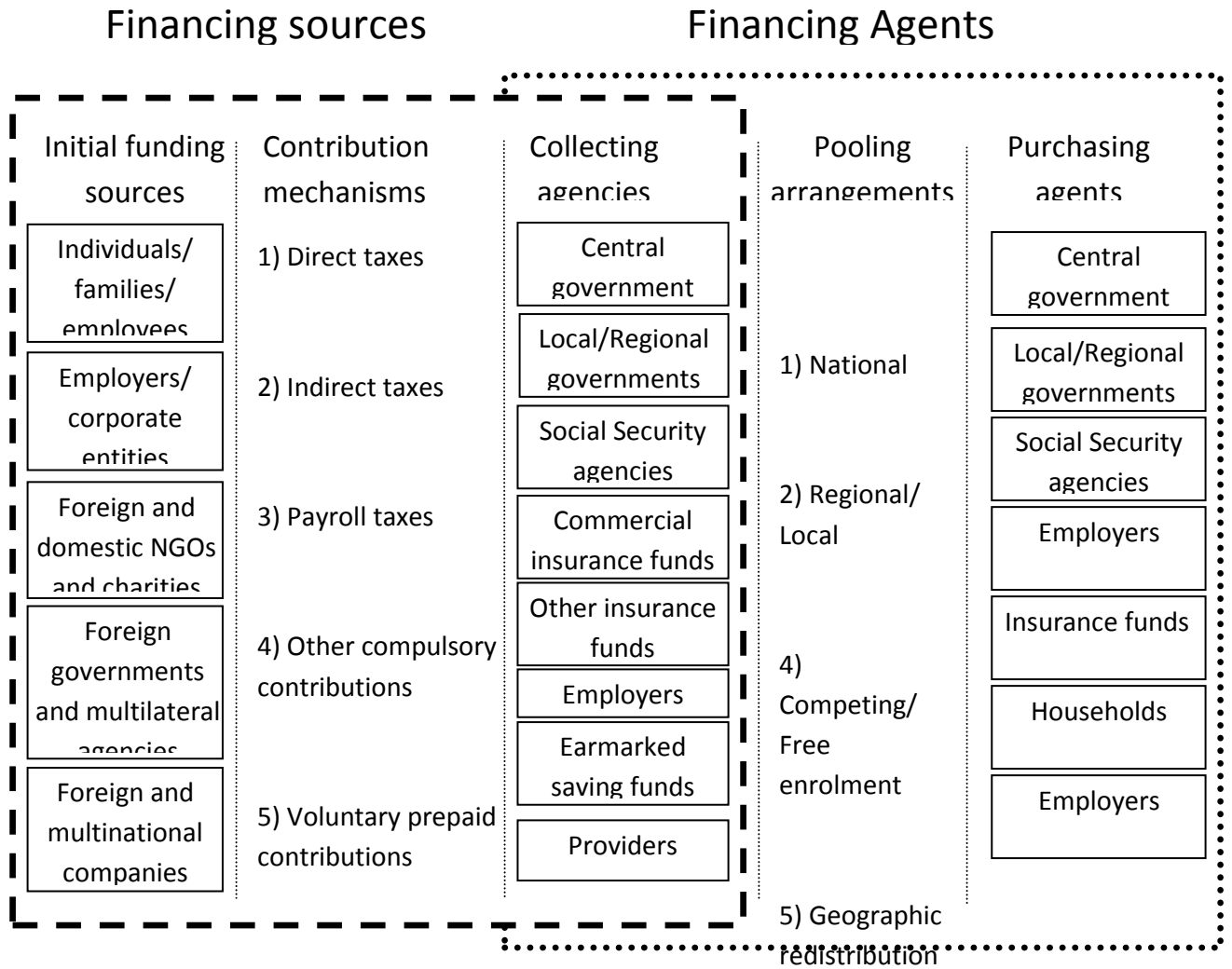
1. The proposals in this paper are based on both conceptual and empirical grounds, as well as a concern with policy relevance. For the latter in particular, it is important to apply the logic of the “functional approach” to health financing¹, and make the NHA classifications consistent with it. This is based on disaggregating health financing systems into the functions of revenue collection, pooling, and purchasing, as well as explicitly identifying policy on benefit entitlements and related rationing measures. Most importantly on the policy side, however, is to ensure that the new NHA classifications are sufficiently flexible to account for innovative “mixed” arrangements. The current classifications are too rigid, and this limits their policy relevance.

2. Classifications are by nature a way to describe reality in a simplified way. It's grouping similar entities into one, creating exhaustive and mutually exclusive groups. Since similar but not identical entities are grouped, entities providing different types of functions are given one name. Therefore classifications will to some extent always lead us into labels. But the challenge is to have the classifications based on their function to the largest extent possible, and have these classifications separated so that they provide the most relevant information possible for health policy.

3. In this paper, some suggested changes only needs changes in definitions, not the classifications (e.g. what is private/public on sources level) but still have important implications, while other things need actual development of the classifications. The classifications can look very different depending on how they are defined. To show this, and to help the discussion, reference is made to Figure 1 in the text. The intension with Figure 1 is to show the complexity the SHA system aims to capture in a comprehensive description of sources and agents/schemes, and examples of what is referred to as sources and agents when they are discussed. It is an illustration only, and does not claim to be a comprehensive description of how funds flow prior to the health service delivery system. It highlights some of the problems with the current SHA 1.0, and supports discussion of the new SHA 2.0.

¹ See *Health financing policy: a guide for decision-makers*, <http://www.euro.who.int/Document/E91422.pdf>

Figure 1 Examples of possible organizational units and funding arrangements to capture in a health accounting framework.



Financing sources

6. The financing sources level is intended to bring in a dimension of “from where does funds spent on health come”. It is intended to provide information to how equitable funding is, give an indication of how well positioned the system is to protect the population from financial risk, and in low-income countries give an indication of how dependent the system is on donor funds. Depending on how the term "sustainable" is defined, it can also provide information on sustainability. Figure 1 illustrates that financing sources can not simply be defined as institutional units providing funds to financing agents or schemes.

Public and private sources

7. It is important that the classifications make economic and policy sense. From the perspective of equity in funding, individuals and firms are the source of all funds (leaving foreign sources aside), i.e. government must get its money from somewhere. This is why, in equity analysis, the contributions from all sources (e.g. general government funds) ideally have to be attributed back to households.² This type of research provides evidence of how the funding of health is distributed across income or consumption groups in a society. But this type of in-depth analysis is costly and information is not provided by routinely produced data. It is unlikely to be part of regular health accounting. But while everything can be attributed to the initial source, for which everything is private (Figure 1, first column), public funding in health is crucial to attain policy objectives of equity and financial protection and public funding serves as a good indicator. Public resources provide a basic risk pooling mechanism, and typically provide an effective redistribution from people able to pay to people in need of care, compared to private resources. Therefore it's crucial to keep a clear public/private split between sources of funds in the new SHA and define public and private not by contribution mechanism or collecting entity, but based on an economic rationale. These examples also show that international reporting, to make comparisons of sources possible, is most relevant. In fact, current international comparison of public/private funding of health shows how big share of health is paid by a public or private entity, which can substantially differ from who is funding health.

8. When defining what is public and what is private, an important change has to be made, which is the classification of compulsory contributions to insurance funds by firms and individuals as “private” sources. In the current PG, as well as in the explanatory notes to the OECD, EUROSTAT and WHO joint data collection, general tax revenues are considered public, but payroll taxes (i.e. compulsory contributions to social health insurance funds) are considered private. The rationale that some give is that the sources should reflect the “proximate sources”, i.e. where was the money just before it entered the health sector. Or that the sources are where the funds provided to the agents last came from. But this approach does not stand up to scrutiny. Figure 1 shows the different entities which are involved as initial sources (no public entities), contributing mechanisms, and collecting agencies. It shows how difficult the distinction is and suggests that if it was practically feasible, several classifications should be created, in order to make it possible to describe complex systems. Figure 1 shows how a payroll contribution can be described as a contribution mechanism, while it's not a source itself, neither an organizational entity. Since the starting point is that classifications inevitably will simplify reality, it needs to rest on a conceptually clear basis, which is the most useful for economic and

² See for example Wagstaff and van Doorslaer 1998, *Equity in Health Care Finance and Delivery*

health policy. Only the legal status of the last entity before reaching the agents level is not a relevant criteria.

9. The key distinction between public and private should be the distinction between whether the contribution to the common system is compulsory or voluntary. If you have to pay something, it is a tax; if you don't, it is voluntary.³ This is also the principle in public finance, payroll taxes are part of "fiscal space". Country reports by the IMF make this point – the consolidated budget of the government includes social security funds. It also gives data which is consistent with how many countries cross-subsidize between general tax-funded and social security funded activities outside the health sector. Pension-schemes, unemployment-schemes and other social sector activities are very seldom totally separated. Governments can to a varying extent usually move financial resources between different sectors and contributing mechanisms, regardless if they are funded by general taxes or pay-roll contributions.

10. For the classification of sources this has a few implications. First, a basic public/private split of health funding is needed. Since the agent/schemes level effectively is a description of how purchasing of health is organized (and to some extent pooled), it is on the sources level the public/private split is relevant. In deciding if a source is public or private it's not adequate to look at the sector it's coming from, but what triggered the payment. A pay-roll contribution is a source generated from labour, paid to and pooled by the government, regardless of the employer is in the government sector or a corporation. For this reason the sector classification proposed by Centers for Medicare & Medicaid Services⁴ is not sufficient. It can very well be used, but only if the descriptions of FS 2 and FS 3 are modified and defined in a way that compulsory payment to a common system is public.

External resources

11. The new SHA must be more helpful in defining and classifying external resources to help countries track external funding. The Producers Guide is not clear on what counts as external support. From a recipient country perspective, the disbursements from donor countries are not a useful measurement of how much support is given. First, much of the spending is never spent on the countries' health systems, but on the donors' administrative functions. Second, technical assistance provided in a recipient country is in current practice valued at market prices in the country from where the funding is coming. In many cases the support would not have been requested if the low-income country would fund the technical support with domestic resources

³ Compulsory payments to individual pools (as opposed to common) must still be considered private as long as there is no redistribution function (except over time).

⁴ See input documents for Units 9 and 10 at www.oecd.org/health/sha/revision

at the same prices. In economic terms, it's the alternative costs of the services in the recipient country which is relevant for policy questions like dependency on aid and sustainable financing. Therefore this expenditure does not provide a useful comparison of domestic and external resources. This principle has been made clear for goods, e.g. medical goods are counted at domestic market prices, not what they are actually purchased for. The same should apply to services. In practise, this is very difficult, and therefore the new SHA should provide clear guidance to what is external support for health. In doing so it should have country relevant expenditures as the starting point. A practical solution might be to value technical support by a quantity times price approach, in which the price is set locally.

12. The current recommendation to classify remittances from family members abroad as household funds should also be changed. If the family members generate their income from labour abroad, they are most likely foreign residents and their contributions are external. It is also part of the recipient country's dependence on external financial resources and should be counted as such, preferably in a separate sub-category.

Tax expenditures

13. Tax expenditures, or forgone taxes, are not captured by a health accounting system, simply because no transaction is made. In a framework measuring expenditures this is correct. But when the new SHA opens up for additions, outside the so called "core framework", this category is relevant as a cost item. Just like un-paid home production of care is not accounted for but recognized as a cost to the system, forgone taxes can be summarized as an additional item, in addition to total health expenditure. This would not be a central part of the SHA, but recognize these tax expenditures in the health sector.

Classification of Financing Agents/Financing Schemes

14. The distinction between sources and agents is very important, especially in light of some of the innovative mixed systems. The fundamental problem with the current HF classification is well described in the OECD input paper *A Proposal for the Main Categories of Financing Schemes* with categories and their definitions being a mix of institutional units and financial arrangements, or "schemes". This arbitrary labelling of categories can be avoided by the approach proposed in the paper. Some of the categories are not necessary however, which is explained below.

15. For the criteria developed in the OECD input paper to classify the agents/schemes it's suggested that "Methods for raising funds" or what is called contributing mechanism in Figure 1, is taken away. The collection of funds is strongly associated with the sources of funds and the type of policy questions this dimension tries to inform, foremost equity in funding. Furthermore, the proposal would benefit from a reduced number of main categories.

16. A challenge for the financial agents/schemes dimension is that one category needs to reflect two health financing policy functions (pooling and purchasing), as illustrated in Figure 1. It is not an issue for most countries, because it is usually the case that the same agency integrates the functions of pooling and purchasing. This is not always true, however. Some countries with multiple insurers have a risk adjustment mechanism that sometimes involves an additional entity that is solely responsible for redistributing prepaid revenues between insurers or even between regions. Such entities pool funds but do not purchase services, and there is no agents classification category for them.

17. With regard to private agents, the term "private social insurance" is not very descriptive. In health, "group health insurance" is the accepted term. It's suggested to keep this category, but rename it.

18. Of the proposed classifications some are questionable based on the above discussion. The second category, "National Health Insurance", NHI has no different characteristics from "General government programmes" for any of the criteria set up for distinguishing the categories. The NHI is funded by earmarked taxes. But the starting point for the HF classification is that it should capture the pooling and purchasing functions of health financing. The form of sources of revenue should not affect the labelling of these functions. If important to distinguish, it should be done on the sources level.

19. It is not clear what information the proposed category "Voluntary medical savings accounts" is intended to provide. As indicated in the paper, it is very close to general individual savings. In the case the individual has no possibility to use the funds for anything else than health, it can be justified as a category of its own. But there are good reasons to try to limit the number of categories and this would be used by very few countries.

20. Community Based Health Insurance (CBHI)⁵ is in effect small scale Voluntary Health Insurance (VHI) programs, but with a participatory approach in management. Other differences are that the number of participants is typically smaller than contributors to a VHI scheme and ownership is non-for-profit. But while it takes very different forms, it inherits some of the same basic problems as voluntary health insurance, e.g. exclusion of the very poorest, despite that risk protection for the poor is often an objective with setting them up, moral hazard and adverse selection of participants. On the positive side studies have shown that the local connection and a community approach creates a social control and peer pressure which helps keeping people in the scheme and use its resources efficiently.⁶ It is suggested that CBHI is given a lower level digit below VHI.

21. In the current SHA, Non Profit Institutions Serving Households (NPISH) is defined as "non profit organizations which provides goods and services to households that are free or at prices that are not economically significant" (SNA 93, 4.64, alt SHA p. 156). But many NPISH in the health sector does in fact produce goods and services at market prices. In the HF classification, the relevant distinction for middle and low income countries is not whether the agent (which in most cases is the same entity as the provider) is producing its services at market prices or not, but whether its separate from the government or not, sometimes called "the third sector" of the economy. The distinction is important because it provides information about the role of the government and the fragmentation of the system, or parts of it (e.g. public health interventions). This can be at market prices or not, and for or non for profit. The term non governmental organization (NGO) would be clearer for this purpose and a more relevant group of financing arrangements. The "Donation-funded health programmes" as suggested in the OECD input paper is determined by revenue collection method which is suggested not to be a criteria.

22. There is also clearer guidance needed on what is NPISH and what is foreign funding on the agents level (HF 2.4 vs HF 3 in the current classification). If the SNA definition is followed

⁵ **A Community-Based Health Insurance Scheme (CBHIs)** is any program managed and operated by a community-based organization, other than government or a private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of health care services. Beneficiaries are associated with, or involved in the management of community-based schemes, at least in the choice of the health services it covers. It is voluntary in nature, formed on the basis of an ethnic of mutual aid, and covers a variety of benefit packages. CBHIs can be initiated by health facilities, NGOs, trade unions, local communities, local governments or cooperatives and can be owned and run by any of these organizations (Jutting, J., 2002, *Do Community Based Health Insurance Schemes Improve Poor Peoples Access to Health Care: Evidence from Rural Senegal*, World Development Volume 32, pp. 273-288).

⁶ Tabor, Steven R., 2005, *Community-Based Health Insurance and Social Protection Policy*

strictly the NPISH is national since it's a residential unit in the country. But it can also be interpreted as in Ukraine, where the NHA team argued that the NPISH organizations in the county are controlled by their foreign funders, therefore effectively are foreign entities, i.e. its foreign because the NGO name is foreign or the organization is generally managed by a foreign entity. But NHA implementation experience also gives examples of when countries where all NGOs are registered and approved by government. The government can then argue that its government spending since the government approves all foreign support to these organizations. This is using the same argument as in the case of Ukraine, the financing agent is the entity deciding how to spend the resources, i.e. it is government spending because it has been approved by the government. This is especially popular in the government because the gives higher levels of public spending. It should be made clear in the new SHA that the guiding principle is who decides about the program of work, or the content and beneficiaries of the services, is the agent, regardless of the residence of the organization.