

Comment Unit 9 & 10

Unit 9 and 10: Classification of Financial Agents/Schemes and Financing Sources

Summary

This paper provides inputs to the Units 9 and 10 on Financing Sources and Financing Agents/Schemes respectively. Many low and middle income countries have adopted National Health Accounts (NHA) as a tool of tracking the sources and utilization of health resources. In the Guide to producing national health accounts with special applications for low-income and middle-income countries, WHO, 2003, the financing sources and Financing agents/schemes have been defined. For countries adopting the System of Health Accounts (SHA) as their national standard of tracking health spending, it is important that their policy relevant issues are sufficiently addressed in the revision.

The SHA revision provides a forum for harmonizing and standardizing the definitions that will ideally allow for cross-country comparison of statistics generated by the health accounting framework. This paper will attempt to provide inputs to the SHA review process reflecting the needs of low- and middle income countries. The first part of the paper will provide inputs to the financing sources while the later section will provide inputs to financing agents/schemes.

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System of Health Accounts (SHA) revision process

Unit 9 and 10: Classification of Financial Agents/Schemes and Financing Sources¹

by

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Background

This paper provides inputs to the Units 9 and 10 on Financing Sources and Financing Agents/Schemes respectively. Many low and middle income countries have adopted National Health Accounts (NHA) as a tool of tracking the sources and utilization of health resources. In the Guide to producing national health accounts with special applications for low-income and middle-income countries, WHO, 2003, the financing sources and Financing agents/schemes have been defined. For countries adopting the System of Health Accounts (SHA) as their national standard of tracking health spending, it is important that their policy relevant issues are sufficiently addressed in the revision.

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A) Financing sources

Disaggregating of Rest of the World

The two documents A System of Health Accounts, OECD, 2000 and A proposal for the main categories of the classification of financing sources (ICHA-FS) by center for Medicare & Medicaid Services, 2008 (Input Document for Unit 9) propose that we combine the financing sources into three broad categories-FS 1-General Government units, FS 2-Private sector and FS 3-Rest of the World. Low income countries may wish to disaggregate the sources further based on policy relevance. Countries which are donor dependant may want to disaggregate the Rest of the World category as follows:

¹ This input paper has been commissioned by the World Health Organization. The views expressed in this paper are those of the author and do not necessarily represent those of the World Health Organization.

- FS 3: Rest of the World
 - FS 3.1 Grants
 - FS 3.2 Loans

This distinction is important for countries to estimate their dependency on external financing. Loans (plus corresponding interest), although sourced externally, can be a more sustainable source of financing, as long as the loan is being serviced, because governments are the ones bearing the burden on loans, and repayments are already factored as part of government revenue and form the first charge of any government expenditures. This is true if the government does not finance its system through too many loans. Also, countries engaged in concessional loans, which can be repaid at a lower rate and over a very long period of time, sometimes run the risk of over borrowing, which is unsustainable over time.

On the other hand, when there is a large grant element, governments must develop policies to replace these grants by another sustainable source of health financing. Since the continuation of most of these grants is unpredictable, it is difficult for governments to forecast their investment in health sector beyond the grant period. Sometimes when the relationship between donor and the recipient country is sour, countries are forced to reduce allocations to the health sector, thereby jeopardizing the programmes.

Another option is to treat loan (excluding concessional loans) plus corresponding interest as General government funds and add them to FS. 1. This option would be applicable to middle income countries that are relying on open market to finance their development agenda including health. In this case only grants should be classified as Rest of the World. If loans were to be accounted for under FS.1, the guidelines need to provide information on how to account for borrowed money. Currently, only the expended part of the loan is accounted for each year, and interests are supposed to also be accounted. But this does not help trace debts, which is an issue already raised in other input papers or proposals (see issue of "surplus" below).

Measurements of remittances by private households

Private households are a major source of health care expenditures either through OOP (cost-sharing and co-payments) or payment in support of home health care. Data for tracking expenditures by private households is weak and countries have to undertake specific household expenditure and utilization surveys to obtain this information.

While low income countries are able to estimate the OOP expenditures, they are however unable to estimate costs for home based care, since this would require estimation of opportunity cost for the care givers and value of in-kind support by family members (food, nursing care). Hence expenditures from most low income countries would exclude although important remittances for home health care services.

Inclusion of an optional source of source table

A central policy concern is to measure spending targets such as the conditions of the Abuja declaration, stating that all African countries will commit 15% of their government budget to health. If designed properly, the SHA could help to identify spending that accounts for this 15%.

But what exactly is "government budget"? Is it determined at the agent level, the source level or perhaps a level before that? If government budget is not meant to include external donors for the Abuja declaration as should be the case, then we need to know the source of source so we can figure out what amount is government budget and what is not. But neither the current SHA nor the Input Document Unit 9 gives the ability to determine the original source of the funding.

The above analysis will become more important as donors shift their financing to budgetary support. We need to understand whether donor's funds are additional and to what extent governments are prioritizing health in their development agenda. The movement of the ratio of health expenditures to general tax revenue will indicate the government commitment to health sector. The source of source table (see Table 1) will help us understand all these issues. Some of the sources of funds for financing source include bilateral donors, multilateral agencies and general tax revenue.

Table 1²

| Financing Source | Original Source of Funds for Financing Sources | | | | |
|---------------------|------------------------------------------------|------------|---------------------|------------------|-------|
| | IMF | World Bank | General Tax Revenue | Bilateral Donors | Total |
| Ministry of Finance | A | B | C | D | E |
| | | | | | |

In calculating the movements towards achieving the Abuja targets, one needs to divide health expenditures by general tax revenue (C), as opposed to the current scenario where health expenditures are divided by E (less earmarked funding by the donors for the health sector). As more funds become available through budget support (especially for Highly Indebted Poor Countries (HIPC)), Ministry of Finance report all funds as General revenue, making it difficult to assess shift of government resources to the health sector.

If one looks at 2008/ 09 Budget Outlook Paper (BOPA) for Kenya³, you will see increase of resources to the health sector by almost 85 percent over the last three years but a closer look at government allocations (which equals expenditures) reveals that they have only grown by 23 percent over the same period.

The source of source table also allows for all taxes to be considered as household spending, while at the financing source level some taxes are considered to be public while others are considered private.

² This table can be modified depending on policy needs of a particular country

³ BOPAs for Kenya are available on www.treasury.go.ke

How to treat surplus funds?

There are some institutions who report surplus or deficits every year in their accounts. Employers or households will record that a health expense has occurred the year of the transfer but the funds may not be used to purchase health until later. Consider this following example:

- In Kenya, the National Hospital Insurance Fund (NHIF) which is an agent reports surplus almost equal to 30 percent of the premiums paid. The current structure only considers return on assets held that is spent on health during each year, in this case interest on surplus would be recorded as FS. 1.2.1. The expenditure matrixes would only capture total health expenditure by the institution which excludes surpluses. While the source will report to have generated more funds, in NHA at source and agent levels, only the spent share will be recorded, which represent less than generated. For the purpose of expenditure tracking only, what is reported by the agent as spent is recorded at the FS level, with the savings not counted at all. How would SHA ensure that the medical savings are captured in the accounts? The current structure including the NHA do not record these medical savings or surplus and since more funds are likely to be passed to these kind of institutions by households or employers it would be important for this issue to be considered during the review of SHA.

Clarity on Non-profit institutions serving households (NPISH)

The non-profit institutions serving households (NPISH) are presumed entities providing services for free or at prices that are not economically significant, and whose main resources are voluntary contributions by households (SNA93) - is this not a contradiction? It would suffice to define NPISH as not-for-profit non-governmental organization providing health services to households. In most low income countries, NPISH are registered as NGOs and receive most of the funds from FS.3 and generate very little which is accounted at the source level. That's why NPISH as source accounts for very small amounts of THE⁴.

Addition of parastatals category

In low income countries there exist many state owned (either fully or quasi) entities commonly known as parastatals which receive funds from General Government in the same form as local authorities. These agencies use funds allocated to them to either insure the employees or provide on site health services. Hence, the need to include:

- HF. 1.1.4 Parastatals or Parastatals Employer Funds, so that we don't lose sight of their health expenditures.

Measurement of Catastrophic expenditures

The current SHA lumps together co-payments and out-of-pocket expenditures to estimate the households' expenditures. Understanding the role of out-of-pocket in financing health is critical

⁴ In 2005/06 NHA for Kenya, NPISH accounted for 0.09% of THE

since (a) catastrophic expenditures are often funded through user fees at the point of seeking care putting households deeper into poverty⁵ and (b) user fees may restrain access to care. Countries, whose total health expenditures are to a large extent financed through out-of-pocket, may need to disaggregate the Household source into two categories as provided below. This information which is generated from household expenditure and utilization surveys can be triangulated with household's income to estimate catastrophic expenditures.

- HF.2.3 Private Households
 - HF.2.3.1 user fees (excluding co-payments)
 - HF.2.3.2 Co-payments

This may be a simplified modification to Table 11.1 ICHA-HF-Classification of Health care Financing: three digit levels. Any further breakdown as proposed may be too complex for low income countries and may not have any policy relevance. The above categorization may assist countries to assess the transition of their health care system over time from being dependent of out-of-pocket to insurance.

Underestimation of household as a source (out-of-pocket expenditures)

In many low income countries health systems are financed by households through out-of pocket expenditures. In SHA, health expenditures are restricted to activities based on “medical” technology. This excludes goods and services purchased from the informal or possibly illegal providers (eg traditional healers), thereby underestimating the household contribution to health.

Clarification on FS. 2.5 Corporations (other than health insurance)

These are private employers who pay insurance for employees or finance in-house clinics or pay medical expenses to contracted providers. On Page 75 section 6.23 of SHA, it is indicated “that employers social contributions are considered part of household incomes and consequently as private household funding of health care not as funding by enterprises”. Private employers in some low income countries are, as part of their social responsibility, extending health benefits to the employees’ families (e.g. they are allowing family members of an employee to access health services at company clinics or providing ART to spouse). All these expenditures have a social contribution perspective. These expenditures would be recorded as being borne by the enterprises and would have a zero price from households side. They should indeed be treated as corporation expenditures. The issue is how then would we isolate the social contributions?

Exclusion of capital from current health expenditure

Although the inclusion of capital formation will be comprehensively addressed in the boundary section, the fact that goods and services are at purchasers’ price (which includes value of

⁵ In 2003, it was estimated that catastrophic expenditures put 1.5% of households below the poverty line annually

depreciated capital for the accounting period), its exclusion may result to data conflict between the sources and agents. Therefore, capital expenditures may already be embedded in prices paid by financing agents.

B) Financing Agents/Schemes

This section will be based on the input document to unit 10 prepared by Health Division, OECD. Since financing agents ultimately make decisions on the allocation of health resources, a transparent understanding of their expenditures is important for the review of linkage between expenditures and sector priorities.

Financing agents may be defined “as institutions receiving and managing funds from financing sources to pay for or purchase health goods and services”⁶.

Unit 10 on Financing Agents/Schemes does not allow for optional multiple layers of financing agents. These optional tables would show the intermediate transfer of funds that takes place before funding ultimately reaches providers, giving countries the ability to identify inefficient financing agents that charge high administrative costs. There is great need in countries with pluralistic systems to recognize administrative costs at each financing agent level to identify inefficiencies.

Consider these three examples

- 1) A donor (source) gives funds to an international NGO, who passes money to local or country NGOs to implement certain health functions. At each stage NGOs keep funds for administration, which may be as high as 30 percent, meaning that for every \$ released by the donor only 40 US cents goes for direct delivery. In most low income countries which are discussing Joint Financing Agreements (JFAs), the tracking of use of health resources at each level would be of policy relevance⁷.
- 2) What if the MoH gives money to an NGO? This scenario is applicable with the disbursement of Global Fund for AIDS, TB and Malaria or
- 3) A donor provides funds (in most cases these are tied loans) which will be sourced from a bank and passed to a firm for procurement of commodities In the government appropriation accounts, the entire amount provided by the donor will be recorded as expenditure (as long as relevant supporting accounting documents are obtained from the donor), without netting of the administration cost of each of the agents.

Currently, if we apply the SHA framework we would be forced to assign this spending to only one of these financing agents. An optional series of tables to track flows between financing agents would be useful for many countries, while not requiring those countries that do not want to utilize the tables to do so. However these optional tables would have such profound policy implications in low income countries as they would facilitate understanding the economic efficiency on the use of scarce resources.

⁶ Current definition used in National Health Accounts which most low income countries are applying

⁷ This is expected to a major policy issue as countries conclude their JFA

Add Parastatals companies

As discussed in the Financing source section, government and donors pass funds to parastatals as agents. These funds could be used for health service provision or research activities. Since there are times when these entities mobilize funds for research on health, without making reference to Ministry of Finance, Governments would be interested to know the magnitude of these in-flows.

Inclusion of Government Ministries as agents

In most low income countries Government through Ministries of Health continues to be a major provider, in addition to regulating health care delivery. The Ministries of Health, Defense, Local Governments and Office of the President are major recipients of central government and Donor funds. They account for more than 30 percent of the current health expenditures. In constructing the financing schemes/Agents, consideration should be made to include these agents. You will find these agents in most NHA reports classified as follows:⁸

| | |
|------------|---------------------------------------------------|
| HF.1.1.1.1 | Ministry of Health |
| HF.1.1.1.2 | Office of President (incl. NACC) |
| HF.1.1.1.3 | Other Ministries (Ministry of Education, Defence) |
| HF.1.1.2 | State/Provincial Government |

The lumping of these agents as Government-funded schemes may not suffice for low income countries.

References

- 1 Guide to producing national health accounts with special applications for low-income and middle-income countries, WHO, 2003
- 2 A System of Health Accounts, Version 1.0, OECD, 2000
- 3 A proposal for the main categories of the classification of financing sources (ICHA-FS) by center for Medicare & Medicaid Services, 2008 (Input Document for Unit 9)
- 4 Economic Surveys, Ministry of Planning and Economic Development, Kenya
- 5 Government of Kenya, Appropriation Accounts
- 6 Budget Outlook Papers, Kenya
- 7 National Health Accounts 2005/06, Ministry of Health, 2008 (unpublished)
- 8 Various input documents to SHA revision process

⁸ This is extracted from Kenya NHA 2005/06