

Revision of the

System of Health Accounts

ORGANISATION
FOR ECONOMIC
CO-OPERATION
AND DEVELOPMENT



World Health
Organization

Input Document
Unit 9 &10

Comments from WHO regional consultation

Author WHO
Affiliation WHO
Submitted on 28/07/2009
Document code SHA-REV- 09204

*The opinions expressed and arguments employed herein do not necessarily reflect the official views of the **Organisation for Economic Co-operation and Development** or of the governments of its member countries, those of the **World Health Organization** or those of **EUROSTAT** or the **European Commission**.*

Units 9 and 10 comments from WHO regional consultation

The Accounting of Health Financing

The World Health Organization has conducted regional three days consultations with separate sessions devoted to each of the Units in the SHA revision. National experts in health accounting and health financing policy have been invited from member states in the respective regions. Because comments represent the views of different regions, they may vary or even contradict each other.

Regional Office for Africa, Nairobi 15-17 April 2009

As a general comment it was raised that while Unit 8 is very rigid with very specific classifications, this unit provides classes with much flexibility.

Under main purposes the question "Where does the money go?" is not specific enough and answers are given which relates only to dimensions of providers and functions. Equally important is the notion of beneficiary groups.

The basic suggested classifications were generally accepted as a possible way forward and an improvement compared to today's more limited FS and HF. But it is difficult to assess the full implications of them in practice, which will take more time.

Several comments were made on the terminology;

The word program in "government health programmes" and "NGOs health programmes" should be avoided since "health program" refers to a set of services in many countries. "General government health funding" is one option.

The name "scheme" is preferred over "sub-system".

It is also suggested to use "institutional units" at revenue level as opposed to sectors (IS). This is suggested because the units is understood to be the same on both levels.

A crucial discussion was held about what translates into the "programmatic responsibility" in the new classifications, which is a crucial element in defining today's HF classes, and described in the PG. Intuitively it's the units classifications. But then the distinction between the schemes as description of financing mechanisms, and units as the organizational structure, is lost to some extent. The concept of programmatic responsibility has to some extent solved the lack of that distinction in today's classification.

Of the two options A and B on how to classify the "schemes" (page 41), option A is preferred over B since it gives a good first digit level grouping of the classes. Further grouping is not needed.

The meeting also discussed the accounting of external financial resources but no conclusion was made. Some countries argue that all resources except direct health funding should be excluded because it cant be attributed to health more than by using a distributional key (e.g., general budget support).

Regional Office for South-East Asia and Regional Office for the Western Pacific, Seoul 6-8 May 2009

It is recommended to have a summarizing introduction of the rationale and conceptual framework behind the new proposal.

An additional purpose of the SHA framework under Point 4 is suggested: "To track the linkages and economic transactions between the sources of revenue, the financing sub-systems (financing schemes/ "building blocks") and the institutional units (financing agents) for health care services and goods based on the boundaries of the framework."

The classification and rationale should be better explained using the principles of healthcare financing of revenue collection, pooling of finances and purchasing, using Table A5.1 in pg.90,

- Revenue collection (Collecting agency (IS), Types of revenue (R) – the "sources of sources"),
- Pooling of finances (Financing scheme / sub-systems (HF))
- Purchasing services & goods ('purchasing agents' / 'financing agents' / 'building blocks' (FS))

The meeting discussed how the Employees Provident Funds (EPF) in Malaysia can be classified in this proposal. In the current SHA there are also ambiguity with this type of compulsory saving with very vaguely specified areas of use. Furthermore the meeting suggests using 'voluntary insurance' instead of "Voluntary private insurance".

Of the table 6, option A is preferred, but 5 categories are suggested instead of 4 by splitting the first category into Government Programmes and Compulsory Health insurance.

- On Institutional Sectors/Units (Table 7), option B is acceptable, but its recommended to add social security funds as a second digit classification. For institutional units its also proposed to have an additional financing agent of 'state enterprise'

Table 9 (b) is acceptable with an additional 'R' code for ear marked revenues of government

The "sub-systems" should be able to distinguish:

- HF.2.1.1 as voluntary public insurance - eg. as in Thailand, Laos
- HF.2.1.2 as voluntary private insurance

The accounting of international assistance (Table 13) needs the following changes:

- Additional 'R' code for ear-marked revenues of government
- The meeting recommends that revenues are separated as local and foreign
- Additional first digit classification as foreign revenue (R.8) with second digit classification under this as foreign non-earmarked revenues to government (R.8.1), grants from foreign governments (R.8.2), grants from international organizations (R.8.3) and foreign voluntary transfers other than grants (R.8.4).

To the question whether these proposed classifications for the financing dimensions are feasible, the countries represented agreed that it is - but it requires additional work compared to today's classifications of HF and FS.

The Regional Office for the Eastern Mediterranean and the Regional Office for Europe, Geneva 26-28 May 2009

The governing rules for the schemes should not include "method for fund raising", an aspect which should be captured in the "collection" classification. If the sequencing (left to right) of the governing rules as outlined in chart 1 is also taken out, the schemes would be more flexible and useful. Currently many countries will "get lost" in the decision tree. Georgia was brought up as one example in the meeting. One of their schemes in the country is a general budget funded insurance scheme for the poor. Participation is compulsory by default for all who are entitled, based on income level. But the method of fund-raising is simply general budget, and already there the scheme does not match Chart Without the sequencing and method for fund raising, the schemes can be classified more flexibly based only on participation and entitlements. In the Georgian case as a compulsory social insurance.

The term "voluntary private scheme" should be replaced by voluntary HI without public or private specification. The notion of private is already captured by the participation and entitlement. It will create less confusion with the IU of private entities.

In addition to "Main Criteria defining the different health financing schemes", it would be very useful to incorporate to what extent funds are pooled and redistributed, although this aspect is probably beyond what we can aim for in health accounting.

The meeting accepts Schemes as the 'building blocks' of the Financing system but notes that the term scheme does not seem adequate for OOP expenditure as HH are by definition institutional units. Schemes are operated by IU, and they can also be identical to IU.

Regarding the Terminology for "enterprises", the definition is too narrow. A clearer specification of public enterprises programs should be done, including a definition. Are they dependent for example on public or private ownership? It is suggested that enterprises programs should be stated as "enterprises-organized health care" which cover any type of health expenditure for their employees.

For the options in table 5, A is preferred by the meeting.

It is suggested that the categories of the Classification of Institutional Units (table 7) are consistent with the current HF categories.

The "type of revenue" classification as well as the tables proposed were generally accepted by the meeting

The SHA revision should look into if the problem of external sources (international organizations un-earmarked assistance to governments) can better be solved by T-accounts.

ICHA-R serves the countries represented in the meeting and adds value for policy purposes, but should be prepared in parallel with other matrices to make sure to avoid double counting

Generally the suggested "accounting of health financing" set of classifications seems feasible but needs further exploration. If successful, it would be a great step forward. The new classifications are useful for South East European countries and will improve the description of health financing of many other European countries.

Regional Office for the Americas, Cuernavaca 17-19 June 2009

The main purposes of the accounting of health financing were clearly defined in the corresponding chapter. In fact, the proposal is considered to be a breakthrough in the sense that it presents an adequate and modern idea of the health system and facilitates the analysis of different institutional arrangements. However, the operational objectives need further clarification. For example, the objectives in the identification of flows have to be better specified and their use better explained; likewise, certain terminological confusions have to be clarified, particularly regarding production and functions.

The distinction of financial schemes as the building blocks of health financing, institutional units as agents and transactions are viewed as an appropriate starting point. In fact, this distinction is considered an excellent decision and innovation, since it enables a coherent analysis of the health system and it brings to light institutional arrangements that comprise health systems. It is advisable to adopt the term "scheme" rather than the term "sub-system" in the reference framework. With regard to transactions, it would be convenient to clarify that transactions take place among institutional units, in spite of the fact that they are further reflected as scheme revenues and expenditures for analytical purposes.

A few modifications were recommended: for example, removal of the term "programs" because they are more related to expenditure than to financing. This classifications would be as follows:

HF1. Government Funds

HF1.1 Management of health fiscal resources

HF1.2. Compulsory insurance

All types of insurance are included here: National Insurance, Social Security, Private Mandatory Insurance, Compulsory Medical Savings Accounts, all of which should be considered within a third digit level. Additionally, an "others" category is suggested to allow the inclusion of non identified institutional arrangements.

HF.2 Voluntary Funds

HF.2.1. Voluntary private insurance (it is advisable to include community private insurance and others in the third digit level and within the voluntary private insurance).

HF.2.2. Management and mobilization of funds for non-profit institutions (this title points out the role of NGOs as financing agents and distinguishes them from those that carry out provision functions)

HF.2.3. Enterprises

HF.3 Non-intermediation Funds (households)

This denomination is proposed for direct household payments to distinguish them from other functions carried out by households. This entry excludes payment of voluntary insurance premiums as well as the fees from the compulsory insurance scheme. HF.3 would include co-payment to providers and out-of-pocket expenses.

HF.4 Rest of the World

This category is deemed appropriate.

With regard to the classification of institutional units, Table 7.a is viewed as more appropriate, although further distinctions should be made at a three digit level. In addition: (a) there is an omission in Table 7.a where no distinction between private and public corporations seem to appear (IS2). (b) in Table 7.b a distinction between financial and non financial corporations is made for private institutions, but not for the public ones; (c) in relation to “the rest of the world”, we advise to open an additional category in both tables: IS5.4 Households (residents abroad) in order to capture a very important dimension: the reception of remittances aimed at payment of health expenses.

The unit is considered to be an advance and presents a positive difference in operational terms in comparison to SHA 1.0. The main advantage is that it improves the analytical capacity by making the construction of a health system map possible. In addition, by combining the outputs of these classifications with Unit 11, the analysis aimed at the issue of equity is enriched since it brings to light the impact that each financial scheme has on the social protection of populations. This in turn responds to the information needs of health authorities by providing them with indicators for a better monitoring of health system reforms and performance.

In general, the group agreed that these classifications are viable, but pointed out that it is necessary to carry out case studies in various countries that have different health systems within the region. Specific institutional arrangements were mentioned such as those of the Dominican Republic and Argentina, which need some reflection regarding the classification of certain schemes and financial agents.