

Input Document
Unit 9

A proposal for the main categories of the Classification of Financing Sources (ICHA-FS)

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A proposal for the main categories of the Classification of Financing Sources (ICHA-FS)

Input Document to Unit 9 in the Program of work for the SHA revision

Purpose

1. As countries' health care systems became more complex, it became important to understand who is actually financing the health care through taxes, premiums or other methods. The current SHA manual does not contain a schematic and definitions of these "financing sources"¹. This paper will begin a process of discussing what should be included in these financing sources and how they should be measured in a health accounting framework and how they relate to the financing agents discussed in Unit 10, Classification of Financing Schemes (Financing Agents).

Introduction and Background

2. When the concept of national health accounting was initially instituted, the relationships between the consumer, payer, and provider were less complex. The consumer and the payer were the same person, and engaged with the health care provider in what was essentially a single transaction. Most payments for health care were out-of-pocket (OOP), with only limited private and public third-party health insurance payments. The concept of financing agent or scheme was developed when these third parties tended to pay the health care provider directly in a single transaction.

3. Over time, health care system became increasingly complex. At various points during the last three decades, entities that financed health insurance experienced increasing cost growth. The relationships between the consumers, payer, and provider became more complex and multilayered. Private concerns explored ways to curb cost growth sometimes paying claims directly, and at other times, they used a third-party administrator—often an insurer—to pay claims. In addition, along with public programs embraced alternative structures such as managed care plans, to efficiently deliver benefits to its covered populations.

4. As the public and private sectors began to play much different roles in the development and underwriting of the health care systems it is helpful to take a step back and look at who is financing a nation's health care. This financing can take the form of premiums, dedicated taxes (for example, payroll taxes), general taxes, subsidies, or out-of-pocket spending

¹ We are using the term "financing sources" to be consistent with the established uses in the Joint Questionnaire on Health Care developed by OECD, WHO and Eurostat. However, the exact terminology for this Unit of measure can be discussed. In the US, the term Sponsor is used to describe financing sources, however this term does not translate into other languages.

5. The financing sources influence the health care system because they frequently are where the impetus of change emerges. Financing sources bear the burden of the health costs and policy makers need to understand what affects changes in the health care system will have on them.

Comparison of Financing Schemes and Financing Sources

6. The current SHA manual does not contain a definition or a classification scheme for Financing Sources (ICHA-FS). It is therefore necessary to; define what Financing Sources are, to determine the relationship between these Financing Sources and the Financing Schemes outlined in Unit 10, and to relate the Financing Sources to actors or entities in the overall economy.

7. The discussion draft of Unit 10, Financing Schemes, provides some guidance by depicting Financing Sources as those entities in the economy that provide the resources that the Financing Schemes allocate to health care providers in order to effect the delivery of health care goods and services to consumers . In the discussion draft, these Financing Sources are described as “Institutional units providing funds to financing schemes” (Chapter 10 draft, paragraph 14. Figure 1, page 6). The draft definition of financing schemes from the same draft reads as follows:

Financing schemes are defined as direct payments by households for services and third-party financing schemes. Third party financing schemes are defined as a distinct body of rules, governing the mode of participation in the scheme, the basis for entitlement for healthcare and the rules of raising and pooling revenues of the given sub-system. Health financing schemes are supported by one or more institutional units, but are not themselves institutional units.

8. One of the rationales for the concept of using Financing Sources that are distinct from Financing Schemes is that it eliminates the ambiguity in the current SHA between “financing schemes and the institutional units (organization) managing financing schemes”, (Chapter 10 draft, page 10). The source of this ambiguity is said to be “the definitions for most of the categories of ICHA-HF were taken from the SNA 93 without adequate interpretation for the health sector.”

9. If the distinction between institutional units and “distinct bodies of laws” was not judged to be an operative differentiation – then there would be no need to create a Source of Financing classification that is separate and distinct from a classification of Financing Schemes.

10. We propose that the Sources of Funding be defined as the institutional units that collectively make up the sectors of the economy (as defined in the SNA); that is the institutional units in the business sector, the government sector, the household sector, and the rest of the world sector that sponsor health care by providing resources (in cash and in kind) to health care financing schemes as defined in Chapter 10. The classification scheme proposed below is consistent with this definition.

Current Structure

11. While there is not a definition and structure for the financing sources in the SHA manual, there have been attempts to create a framework for measuring this category. The *Guide to producing national health accounts with special application for low-income and middle income* proposed the following classification scheme²:

Table 1 Proposed classification scheme for financing sources (FS)

Code	Description
FS.1	Public Funds
FS.1.1	Territorial government funds
FS.1.1.1	Central government revenue
FS.1.1.2	Regional and municipal government revenue
FS.1.2	Other public funds
FS.1.2.1	Return on assets held by a public entity
FS.1.2.2	Other
FS.2	Private Funds
FS.2.1	Employer Funds
FS.2.2	Household funds
FS.2.3	Non-profit institutions serving individuals
FS.2.4	Other private funds
FS.2.4.1	Return on assets held by a private entity
FS.2.4.2	Other
FS.3	Rest of the world funds

² To see a full description of the definitions included with these categories reference the Guide

12. The Joint OECD, Eurostat, and WHO Health Accounts (SHA) Data Collection, explanatory notes³ modifies this classification scheme slightly, combining several categories:

- FS.1 General government units
 - FS.1.1: Territorial government
 - FS.1.2: All other public units
- FS.2.: Private sector
- FS.2.1, FS.2.3: Corporations (quasi-corporations) and Non-profit institutions serving households (NPISHs)
- FS.2.2: Households
- FS.3: Rest of the world

13. However, most countries do not report on this dimension, either through a lack of data or a lack of understanding of the concept. The United States has developed an account according to similar concepts, as does Switzerland, France, Luxemburg, and the Czech Republic. Canada is in the process of investigating the development of these types of accounts. See annex 1 for the US methodology and approach.

Discussion Question: What issues are preventing the completion of health accounts by financing sources?

Proposals for the Financing Sources Framework

14. There are several options available as an alternative method of looking at health care spending beyond the financing agent. Two approaches have been defined in previous papers (Notes on Unit 9 and 10). These are:

- a. Option (A): as classification for revenues⁴ /funding sources (e.g., different types of taxes, social insurance contributions, etc.). It seems desirable to develop 3-digit or 4-digit categories in order to better display the revenue structure of health financing (e.g., employer's contribution to social insurance, insurance premium paid by employers, funding sources for employer's own health programmes, etc.). The labels of categories of ICHA-FS should clearly refer to types of revenues. (The

³ To see a full description of the definitions included with these categories see the explanatory note

⁴ "Revenue is an increase in net worth resulting from a transaction" (Source: GFS)

labels of the current categories should be amended accordingly.) Note: DELSA/HEA/HA(2006)7 proposed this option.

- b. Option (B): as entities (actors) providing funds (through taxes, contributions to insurance, premiums paid, transfer payments, and discretionary allocation) for financing schemes. Financing sources are institutional units (including households as a generic group) whose resources are mobilized and managed by financing schemes. Note: the Draft Programme of Work for the SHA Revision contains this option, but this issue is open to debate. If this option is applied, there seems a need for classification of transfers (e.g., different types of taxes, social insurance contributions, etc.).

15. We would recommend a version of Option B. This option measures the funding sources of the “financing agent” which allows users to have a better understanding of which sector is bearing the burden of the health costs. Using the institutional units (household, government, and business or a similar breakout) allows users (not just health accountants) a simple and understandable approach to looking at who is the “ultimate payer of health care”. This also allows analysis of which entities in an economy could have an impact on the health care system structure. As the burden on households become greater they can take action through the political process, through job selection etc, the same is true of the other sectors.

16. While the revenue approach (as spelled in Option A) is a good one, it adds a level of complexity (not only in measurement but also in definition) to the overall concept. For example, when referring to the revenues of private insurance companies, is income outside of the transaction directly related to health care included, i.e., interest income.

17. The revenue approach suggested in Option A also would entail a considerable reporting burden since each Financing Source would have to report the nature of its revenue stream every year. Additionally, health economic accountants would face the difficulty of determining whether a Financing Source should change from one classification sector to another by dint of the change in the composition of its revenue stream.

Discussion Question: In the Table 1 version of the financing sources classification scheme includes a classification for return on assets. Does this have a place in the health accounting framework?

18. The definition of revenue can also add to the complexity. As shown in the Investorword.com, revenue can be defined in 2 different ways depending on whether the entity is a private firm or is government:

i. **Definition 1**

For a company, this is the total amount of money received by the company for goods sold or services provided during a certain time period. It also includes all net sales, exchange of assets; interest and any other increase in owner's equity and is calculated before any expenses are subtracted. Net income can be calculated by subtracting expenses from revenue. In terms of reporting revenue in a company's financial statements, different companies consider revenue to be received, or "recognized", different ways. For example, revenue could be recognized when a deal is signed, when the money is received, when the services are provided, or at other times. There are rules specifying when revenue should be recognized in different situations for companies using different accounting methods, such as cash basis and accrual basis.

Definition 2

For the government, the increase in assets of governmental funds that do not increase liability or recovery of expenditure. This revenue is obtained from taxes, licenses, and fees.⁵

19. It is important to understand that this classification is not a measure of how the revenues are generated by the institutional units in the sectors that make up the various funding sources, but a measure of which sector is paying for the health care expenditures. This analysis can be used as a comparison to the revenues for the different sectors to determine the burden that is being placed on them

20. However, one of the side products of this analysis is to be able to generate tables that can show the revenues for the different categories. For example, the US uses this type of analysis to look at the private health insurance financing scheme and determine where the revenues either are coming from, from employer-sponsored health insurance (corporations, households or governments) or individually purchased health insurance.

Discussion Question: Should revenues be part of the financing sources?

⁵ "revenue" InvestorWords.com. Web Finance, Inc. May 9, 2008
<<http://www.investorwords.com/4254/revenue.html>>.

Proposal on Financing Sources Main Categories and Definitions

21. When developing the definitions and main categories, the proposed classifications as defined in the *Guide to producing national health accounts with special application for low-income and middle income* was used as a model with some slight modification. An attempt was made to ensure that comparability at the most aggregate levels was maintained. While the differences between countries may widen at the more detailed estimates level, the goal of this proposed classification system was to aid the comparisons at the top level between countries while providing a structure for countries to develop accounts that are more detailed.

22. In addition, the proposal measures financing sources at the national expenditure levels. The relationships between the central, regional, and municipal governments are exceedingly complex and vary greatly between and within countries. Developing one accounting system that would satisfy all the different relationships would be an impossible task to accomplish in a short time frame.

Discussion Question: Should a financing sources framework be developed at levels below the national level?

23. Intergovernmental transfers are another complex issue for most countries. When money flows from one government entity to another it is sometimes hard to follow the flow of funds. However, in most cases these other governmental entities are working as financial intermediary. These entities provide no to little value added to the funds but acting as a conduit for the passage of funds, for example taxes are collected from an individual, paid to the treasury or department of finance and then passed on to either the health care provider or the entity that administers the health plan.

24. In our proposed classification system, we would not have a separate sector for these financial intermediaries. The important concept to measure is the origin of the funds (taxes, premiums, grants from sources outside the country etc) not the dispensing government entity. There would an accounting issue if these other governmental entities are financed by many different mechanisms (taxes, premiums, grants etc.)

Discussion Question: Do these financial intermediaries add value to the health system? How should they be integrated into a financing source system of accounting?

25. Tax expenditures⁶ are not included in the classification system. This would be consistent with the treatment of tax expenditures in SNA. The measurement of forgone taxes is invaluable to the budget process. However, it has limited use in an economic accounting system because there is no actual transaction to be measured. Even if the amount of forgone taxes is calculated, there is not movement of funds that would be part of the any accounting system.

26. Figure 2, contains a proposed classification system for financing sources. This is to give a starting point to the discussion. The terminology that is being used is for convenience sake at this point in time but should be reviewed to ensure that it is consistent with other sections.

Figure 2

FS.1.	General Government
FS.1.1	Regional and Municipal government
FS.1.2	Centralized government
FS.1.3	All Other Public Units
FS.2	Corporations
FS.3	Households
FS.4	Other Private
FS.5	Rest of the World

Discussion Questions: What are some alternative terminologies that could be used?

27. Definitions of the proposed classification system:

- Primary categories
 - *General Government Sector (FS.1):* All general revenue⁷ funds (primarily taxes) generated by the various units of central, regional and municipal government. These funds are used to support various health program, including the payment of health insurance premiums or contribution to social insurance schemes on behalf of employees of the government. These funds would be net of intergovernmental transfers.
 - *Regional and Municipal government (FS.1.1):* All general revenue from governments below the central government used to support health programs.

⁶ Tax expenditures are the amount of tax revenues forgone by the government. These include tax credits, subsidies etc, given to corporations or households for premiums or out-of-pocket payments for health.

⁷ General revenue is taxes or other means of generating income that is not solely tied to the provision of health care. For example, income taxes or sales taxes would be considered general revenues whereas payroll taxes earmarked for health care and health care alone would be considered dedicated taxes

- *Centralized Government (FS. 1.2)*: Includes the government at the highest level. These entities would not necessarily be the health ministry but any central government entity used to finance health care using general revenue funds.
- *All other public Units(FS.1.3)*: Public entities that do fit any of the above categories
- *Corporations Sector (FS.2)*: Private entities that provide insurance or pay contributions to behalf of their employees. In addition, corporations may also provide services in-house for employees or pay into worker's compensation programs. The main types of business included in these sector are:
 - Incorporated Businesses: Legal entities recognized as institutional units separate that operate independently of the individuals or institutional units that comprise its ownership
 - Unincorporated Businesses: Businesses that are owned and operated by individuals or groups of individuals who bear the liability for the business's actions. These unincorporated businesses are operated separately from the households of the owners and maintain a separate accounting system from that of the household(s) of the owner(s).
- *Households (FS.3)*: Includes direct payments to providers including payments for services not covered and co-pays and deductibles, premiums for public or private health insurance plans and dedicated taxes for public health insurance.
- *Other private(FS.4.)*: Non-profit institutions serving households (NPISH's) are included in this category along with revenues from non-health activities used to support health care (for example gift shops in hospitals) as well as philanthropic organizations that provide resources to health care financing schemes in cash or in kind.
- *Rest of the world (FS.5)*: Funds not originating from entities resident in the domestic economy, including aid and grants from other governments or from non-governmental organizations and individuals outside the country.

Discussion Question: Is the SNA concept of “economic sectors” the distinction that should be used here? Using that concept unincorporated business are combined with households, and NPISHs are combined with corporate business if the prices the NPISH charges are meant to cover the cost of production.

Next Steps

28. This paper presents a general approach to developing health accounts for financing sources. There are still some major questions that need to be addressed and that we are looking for input. Some of the questions were spread though out the paper, other issues include:

- How are “Sources of Financing” defined? Are these sources of financing to regarded as institutional units, as macro financing “schemes” with the force of law, or as sectors of the economy?
- Is it important or even necessary to categorize the Sources of Financing beyond the basic SNA sectors of the economy — the Government, Business and Household sectors?
- Since the Classification for Financing Sources defines Sources of Financing as institutional units providing funds to financing schemes (Eva’s paper paragraph 14, page 6) what purpose is served by a detailed stratification of these sectors?
- Is the SNA concept of “economic sectors” where unincorporated business are combined with households, and NPISHs are combined with corporate business if the prices the NPISH charges are meant to cover the cost of production, the best classification for the SHA. Should we consider the NIPA treatment? See Chapter 12 of *Understanding National Accounts*.

Of particular concern is the difficulty in dividing the SNA institutional sectors (financial corporations, non-financial corporations, government units including social security funds, non-profit institutions serving households, and households) into corresponding health and non-health segments. In this type of

institutional categorization governments are both direct producers and financing agents (and arguably consumers as well). Corporations that self insure employees could be considered financial corporations irrespective of their designation as non-financial corporations. How to make these distinctions on the theoretical level, let alone address the data development and measurement issues, seems particularly challenging.

29. A series of crosswalks need to be developed that links the financing schemes and the financing sources. Annex 2 contains an example of a crosswalk (or modified t-account) that can be the basis for this type of analysis.

ANNEX 1

30. This annex provides the United States definition and methodology for accounts by Financing Sources.

Definition of Sponsor⁸ and relationship to sources of funding⁹:

31. The basis for sponsor estimates are the health services and supplies (HSS)¹⁰ totals in the National Health Expenditure Accounts (NHEA). The NHEA structure includes measures of spending for sources that pay for health care services. These sources generally define an entity, usually a third party insurer that is responsible for paying the health care bill. These funding sources are broadly classified into private health insurance, out-of-pocket spending, specific government programs such as Medicare and Medicaid, and other public programs such as DVA (Department of Veterans Affairs), DOD (Department of Defense), and Maternal Child and Health among others. Additionally, a small portion of expenditures is estimated for other private revenues – for example, philanthropic giving, industrial inplant, and revenues received by some health care providers from such non-health activities as the operation of cafeterias, gift shops and educational programs.

32. Behind each NHEA source-of-funding category is an individual, business, or tax source (either dedicated or general revenue) that is responsible for financing, or sponsoring, those payments. These sponsors – designated as businesses, households, governments and other private funds – provide the financial support from which health care bills are paid. The difference between sources of funds and sponsor can be illustrated using private health insurance as an example. Although private health insurers pay claims on behalf of individuals covered by health insurance policies, premiums are often paid, or sponsored, by a combination of employers (private businesses, Federal government, and state/local governments), households (as employees or purchased directly by individuals in the form of individually purchased policies), and government (such as the Medicare Retiree Drug Subsidy (RDS) payments to private and state and local employers). So, although private health insurance is considered a private source of funding in the NHEA, in the sponsor analysis it is divided into

⁸ Financing sources are referred to as sponsors in the US; however, the concepts are very similar.

⁹ Sources of funds are conceptual equivalent to financing agents/schemes in the SHA manual.

¹⁰ HSS includes expenditures for personal health care, government public health, administrative cost of government programs and the net cost of private health insurance. For more information on definitions in NHE, see http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

business, household and government sponsor categories based on who bears the underlying financial responsibility for the health insurance premiums.

33. Figure 1 provides an illustrated crosswalk of the transition from the NHEA source-of-funding to sponsor categories.

Figure 1. Crosswalk of National Health Expenditure Payers to Business, Household, and Government Sponsors

Source of Funding	Business, Household, and Other Private			Government	
	Business	Household	Other Private	Federal	State and Local
Health Services and Supplies					
Private Sources of Funds					
Out-of-pocket		X			
Private Health Insurance	X	X		X	X
Other Private Revenues ¹	X		X		
Public Sources of Funds					
Medicare	X	X		X	X
Medicaid ²				X	X
Other Public ³	X			X	X

¹ Other Private Revenues include Industrial Inplant, Philanthropy, and Other Non-Patient revenues.

² Medicaid includes SCHIP expansion (Title XIX).

³ Other Public includes Maternal Child and Health, Vocational Rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Services, Department of Defense, Department of Veterans Affairs, SCHIP (Title XXI), Public Health Activities, state/local workers' compensation, Temporary Disability Insurance, and other miscellaneous general hospital and medical programs.

Methodology of Crosswalk between Sources of Funds and Sponsor

34. *Out-of-Pocket:* Out-of-pocket funding is defined as direct spending by consumers for all health care goods and services. This includes the amount paid out-of-pocket for services not covered by insurance and the amount of coinsurance and deductibles required by private health insurance and by public programs such as Medicare and Medicaid (and not paid by some other third party), and includes payments from health and flexible savings accounts. The definition

and estimates for out-of-pocket spending is the same as in traditional source of funds estimates and in the sponsor analysis, where it is included with spending by the households.¹¹

35. *Private Health Insurance:* To produce private health insurance (PHI) estimates that are the financial responsibility of businesses, households and governments, total PHI premiums excluding the Medicare RDS Payments are disaggregated into employer-sponsored and individually purchased PHI premiums. Employer-sponsored health insurance premiums are defined as premiums paid by employers and/or employees through payroll deduction, whether or not the employer actually contributes to the health plan. Union health insurance plans are also considered to be employer-sponsored plans. Employer-sponsored premiums were estimated separately for private, State/local and Federal employers and each of their employee groups.

36. *Other Private Revenues:* Other private revenues consist of philanthropy, industrial inplant, and other private revenues. For the sponsor analysis, industrial inplant is moved to the business category; philanthropy and other private non-patient revenues remain in the other private category.

37. *Medicare:* Medicare is one of the major public sources of health care in the US. It covers the Elderly and Disabled population. The Medicare program is financed by several different mechanisms. The Hospital Insurance (HI) trust fund is primarily financed through Federal Insurance Contributions Act (FICA) taxes on covered payroll, plus interest, taxation of benefits and other revenues. The Supplementary Medical Insurance (SMI) trust fund (which includes Medicare Part D after 2004) is financed through general revenues, premiums (including buy-ins from Medicaid dually eligible beneficiaries), state phase-down payments, and interest income.

38. In the sponsor analysis, years where the assets of the Medicare HI trust fund increase allow for immediate reductions in current federal general funding obligations for Medicare, as the surplus is recorded as special interest-bearing treasury obligations that are then intermingled with all other general revenue. We report this surplus as an offset to the difference between program outlays and the dedicated financing sources of Medicare. The dedicated financing sources include HI payroll taxes, the HI share of income taxes on Social Security benefits, beneficiary premiums, and beginning in 2006, Part D state phase-down payments.

39. The NHE Medicare 'source of funding' estimates are distributed to reflect these different financing sources. In the sponsor analysis, the HI payroll taxes paid by employers, along with one-half of the self-employed payroll taxes, were subtracted from NHE Medicare estimates and assigned to the businesses and Federal and state/local governments in which employers or

¹¹ National Health Accounts, Web Methodology, National Health Care Statistics Group. http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

self-employed individuals operate. The employees' share of HI payroll taxes¹², together with the other half of the self-employed payroll taxes, HI taxation of benefits, and SMI premiums¹³ were all moved to the household category.

40. Medicare estimates are further adjusted by the removal of Medicaid buy-ins (payments made by state Medicaid programs for Medicare Part A and Part B premiums for eligible individuals). State phase-down payments for Medicare Part D are also reallocated to state and local governments. Additionally, RDS payments are removed from the employer (private and state and local government) share of private health insurance and added to the Federal government Medicare spending category. The remaining Medicare Federal government expenditures are roughly equal to trust fund interest income and Federal general revenue contributions to Medicare and are included in the federal government category.

41. *Medicaid:* Medicaid is combined federal and state and local program for the poor and medically indigent and for children (SCHIP), and estimates of federal and state spending are moved into the appropriate government category.

42. *Other Public:* Other federal public payers consists of Substance Abuse and Mental Health Services Administration, Indian Health Services, Department of Defense, Department of Veterans Affairs, other miscellaneous general hospital and medical programs, Public Health Activities and the federal share of Maternal Child and Health, Vocational Rehabilitation, SCHIP (Title XXI), state and local workers' compensation, and temporary disability insurance. The state and local government programs include the state share of Maternal and Child Health, SCHIP, general assistance, state and local workers' compensation, and state phase-down payments under Medicare Part D. Temporary disability insurance is reclassified from a state and local government source-of-funding category to the private business sponsor category.¹⁴ Other than this, the other public category is identical under the source of funds and sponsor analysis.

¹² Source: SSA Office of the Actuary, private communication. (The Social Security Administration's Office of the Actuary supplied estimates of tax liability for self-employed workers, employees and their employers).

¹³ Source: CMS, Trustees report. (estimates of the taxation of benefits and SMI premiums are from the Center for Medicare and Medicaid Services' (CMS) Office of the Actuary).

¹⁴ A small expenditure for workers' compensation covering Federal employees is the financial responsibility of the Federal government as an employer. In both the NHE source of funding and sponsor presentation, workers' compensation for Federal employers is in the Federal category.

Annex 2

Expenditures	Financing Agents/Schemes	Financing Sources	Financing Sources	Method for financing the schemes
Total	General Government	Households	Household	Premiums
	National Health Insurance	Business		Private plans
	Compulsory social insurance	Governments		Government plans
minus capital investment	Compulsory private insurance & compulsory medical savings accounts	Other Private		Dedicated Taxes
	Voluntary private insurance & individual medical savings accounts	Rest of the World		Payroll
	Community Based Insurance			Other
	Households out-of-pocket payments			Out-of-pocket
	NPISH health programmes & Corporation health programmes			
Current expenditures on health care	Current expenditures on health care			