

Input Document Unit 1

PURPOSES AND PRINCIPLES OF THE SHA

Summary

Countries with pluralistic health systems and limited data capacity have much to gain from the practical approach of NHA as described in the Producers' Guide and country estimations to date. It is also essential that the SHA revisions incorporate the perspectives of policymakers and decision-makers, in addition to health accountants. For nations, particularly low- and middle-income ones, to dedicate scarce resources to the development and implementation of the SHA, they must be certain that the revisions firmly address current and future policy needs.

Author Health Systems 20/20
 Affiliation USAID
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ACRONYMS

USAID	United States Agency for International Development
PHR	Partners for Health Reform
PHRplus	Partners for Health Reformplus
SHA	System of Health Accounts
NHA	National Health Accounts
PEPFAR	President's Emergency Plan for AIDS Relief
MoH	Ministry of Health
ECSA	East, Central, and Southern Africa
NGO	Nongovernmental Organization
MoF	Ministry of Finance
MDG	Millennium Development Goals
IMF	International Monetary Fund
NPISH	Non Profit Institutions Serving Households
NASA	National AIDS Spending Assessment
GDP	Gross Domestic Product
SNA	System of National Accounts

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EXECUTIVE SUMMARY

The following SHA input document reflects the authors' experiences with implementation of National Health Accounts (NHA) in low- and middle-income countries, particularly those countries that have worked with the Health Systems 20/20 project and its predecessor projects namely Partners for Health Reform (PHR) and Partners for Health Reformplus (PHRplus). These projects together represent over 10 years of experience in NHA in low- and middle-income countries, largely in Africa, the Middle East, and Latin America and the Caribbean.

While we comment on many areas suggested by the Invitation for Input Documents, we have attempted to focus our attention on those areas with which we have had the most experience.

1. UNIT 1. PURPOSES AND PRINCIPLES OF THE SHA

1.1 SUMMARY

Countries with pluralistic health systems and limited data capacity have much to gain from the practical approach of NHA as described in the *Producers' Guide* and country estimations to date. It is also essential that the SHA revisions incorporate the perspectives of policymakers and decision-makers, in addition to health accountants. For nations, particularly low- and middle-income ones, to dedicate scarce resources to the development and implementation of the SHA, they must be certain that the revisions firmly address current and future policy needs.

1.2 HIGHLIGHTED RECOMMENDATIONS

- 1) The SHA 2.0 should serve not only as a classification system, but also as a "How-to" instruction manual, as per the *Producers' Guide*.¹
- 2) The SHA 2.0 should accommodate the possibility of multiple layers of financing agents and a potential need to examine the "source of the financing source" level.

1.3 HEALTH SYSTEMS IN LOW- AND MIDDLE-INCOME COUNTRIES

The structure of health systems in low- and middle-income countries is largely based on how revenue collection, risk pooling, and purchasing are organized and financed. Factors including a country's income level, private sector involvement, organizational set-up, and level of external donor participation shape its health system. Many low- and middle-income country health systems consist of a mix of public and private sectors, with the private sector growing significantly in some countries. There are often major structural differences, even among countries in the same region or of similar income level.

From the authors' experiences, low-income countries' health systems are generally geared toward providing basic health care services at a minimum. In sub-Saharan Africa in particular, the government and households have historically been the primary source of health care expenditures, though external donors have recently begun to fund a greater share of total health expenditures through large health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan for AIDS Relief (PEPFAR).² Results from recent NHA activities have shown that this shift has resulted in an overall increase in total health spending in

¹ World Health Organization (WHO), World Bank and United States Agency for International Development (USAID). 2003. *The guide for producing National Health Accounts, with special application for low- and middle-income countries*. Geneva: WHO.

² World Bank. 2008. *World Development Report*. Washington, DC.

many low- and middle-income countries, but has not necessarily led to a significant decrease in the economic burden on households. The private insurance sector is small in many low-income countries and efforts to improve the equity of financing are needed and ongoing. Private providers, including faith-based organizations, street vendors, and traditional healers, are significant players, though the size of their role varies from country to country.

Middle-income countries may not depend on external donors to the extent that lower-income countries do. In Eastern Europe and Central Asia, health systems are often employer-based, financed akin to the Bismarck social insurance model.³ However, a significant share of health spending in this region is paid for out-of-pocket. In Latin America, many countries also have social insurance programs. These countries' impoverished populations usually receive basic care through national health programs.

1.4 CASE STUDY: HEALTH SYSTEMS IN AFRICA AND SELECT ISSUES WITH SHA

Much of the formal health sector in African countries is funded by government and/or external donors, and although the formal private funding sector is underdeveloped in some countries, it is growing. Households make up a large share of health financiers, and in some West African countries, external donors fund up to 30 percent of health care.⁴ A large share of household spending is in the form of direct payments to providers, with much of this out-of-pocket spending paying for pharmaceuticals and medical supplies at informal providers or providers whose main function is not necessarily health, such as shops, mobile street vendors. These payments are not classified specifically as informal purchases under the current SHA framework. Rather, they are captured under HP. 4.1 Dispensing Chemists. It is of great importance to track out-of-pocket expenditures on pharmaceuticals in informal settings because of the high volume of drugs that are bought in this manner. The revised SHA 2.0 could include payments on these items under an "informal provider of medicines and commodities" category. Additionally, private health insurance, social insurance, and community-based health insurance in West African countries cover approximately 8–15 percent of the population.⁵ Health care providers in many African countries are poorly distributed and generally are in short supply. Providers in these countries sometimes accept in-kind payments. The SHA currently focuses on monetary transactions; It would be helpful for SHA 2.0 to provide guidance on how to account for these payments, given their high volume in many African countries. Similarly, guidance is requested on how to account for informal payments given to providers to document "under-the-counter" or "envelope" payments (which may be both in-kind and monetary) to providers to facilitate receipt of higher quality services or to jump the waiting list etc.

³ Gottret, Pablo and George Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide*. World Bank: Washington DC.

⁴ World Bank. 2008. World Development Indicators Database.

⁵ Waelkens, Maria-Pia and Bart Criel. March 2004. *Les mutuelles de santé en Afrique sub-saharienne, Etat des lieux et réflexion sur un Agenda de Recherche*. Health and Population Discussion Paper. Washington, DC: World Bank.

In many African countries, like Rwanda, the Ministry of Health (MoH) finances local health offices, which provide primary care services. Approximately 40 percent of health facilities in East, Central, and Southern African (ECSA) countries are private, faith-based facilities, though they follow government policies and are integrated into the public health care system. This has presented an issue as to whether or not these facilities should be accounted for as private, public, or some other category representing privately funded health centers that are mostly controlled by the government. Like West African countries, many ECSA countries are currently experiencing growth in their private sector, causing traditional medicine to decline in some areas; in other areas, traditional healers still play a significant role in the delivery of health care.

1.5 HEALTH FINANCING SYSTEMS IN LOW- AND MIDDLE INCOME COUNTRIES

Health financing systems in the developing world differ greatly from country to country. Low-income countries often face major institutional, fiscal, economic, and political constraints in providing even a basic package of health services for populations. Notably, it is difficult for many of these countries to generate general revenues, partially due to their sizable informal sectors.⁶ This limits the ability of the public sector to increase its health financing. Revenues for health care typically originate with households and external donors. In sub-Saharan African countries, donors provide approximately 18 percent of total health expenditures, compared with 1.5 percent in South Asia, the region with the next highest level of external assistance as a share of total health expenditures.⁷ Financing and management of funds in many low-income countries in Africa involve multiple financing agents, each of which demands their own administrative expenses. In contrast, middle-income countries typically have a greater ability to generate general revenue. Revenue for health care originates primarily with payroll and general taxes, household out-of-pocket expenditures, and private insurance in many of these countries; primary care for the poor is often government funded.

1.6 CASE STUDY: HEALTH FINANCING SYSTEMS IN AFRICA

Health care in West African countries is financed by three main sources: households, governments, and external donors. Private sources excluding households are an insignificant source of funding. The majority of financing is through health ministries, which designate money to public sector providers. Private sector financing agents, mostly nongovernmental organizations (NGOs), play a minor role. Other African countries have additional levels of financing. Some ECSA countries have four main sources of financing: Ministry of Finance (MoF), employers, households, and donors. In some instances, these sources provide funding directly to providers. However, funds often travel through one or more levels of financing agent, which may include the MoH, NGOs, and community-based organizations.

⁶ Gottret and Schieber, Op cit.

⁷ Atim, Chris, Lisa Fleisher, Laurel Hatt, Steve Musau, and Aneesa Arur. Not yet published. *Health Financing in Africa Today: Challenges and Opportunities*. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.

1.7 PROPOSED FLOW-OF-FUNDS MODEL

There is demand for a flexible health-financing model that takes into account the policy needs of low- and middle-income countries and recognizes that the priorities and structure in many of those countries will shift over time. Policy needs include an understanding of the burden of financing on households, interest to meet Millennium Development Goal (MDG) targets, and many others. Due to the diversity of health financing systems in low- and middle-income countries, there is no “one-size fits all” framework to describe the flow of health care funds. The best way to achieve cross-country comparability is to utilize a simple framework that can be amended to fit individual countries. Project experience and consultations with countries have revealed that low- and middle-income country financing can best be described by a four-dimension system that is malleable enough to allow for additional layers of financing agents and financing sources to be included in optional tables (see chart below). These additional layers are useful because many health initiatives flow through multiple groups before reaching providers and the efficiency of such transfers has become a policy concern.

The suggested format begins with financing sources, such as households, external donors, government, and other private sources. An optional preceding table should be included to account for the entities that finance some financing sources. For example, a country’s MoF might be a financing source; however, a substantial portion of ministry funds may come from an external donor, such as the International Monetary Fund (IMF) or World Bank, as loans to the country. This ultimate financing source should be accounted for because the money did not originate in the MoF, and was not necessarily initially earmarked for health. This has implications for measurement of countries’ meeting the Abuja Declaration (where all African countries committed to allocate 15 percent of their government budgets to health). There has been some question as to whether this should be measured based on the financing source or financing agent level, as there can be a considerable difference on the amount of donor funds that are incorporated at the MoF (In Rwanda for example, approximately 41% of MoF funds are derived from donor grants) or the MoH (donor transfers to a MoH make up over 50 percent of MoH funds in some countries). In the absence of the proposed optional table, guidance is needed for how to account for the “so-called” source of sources.

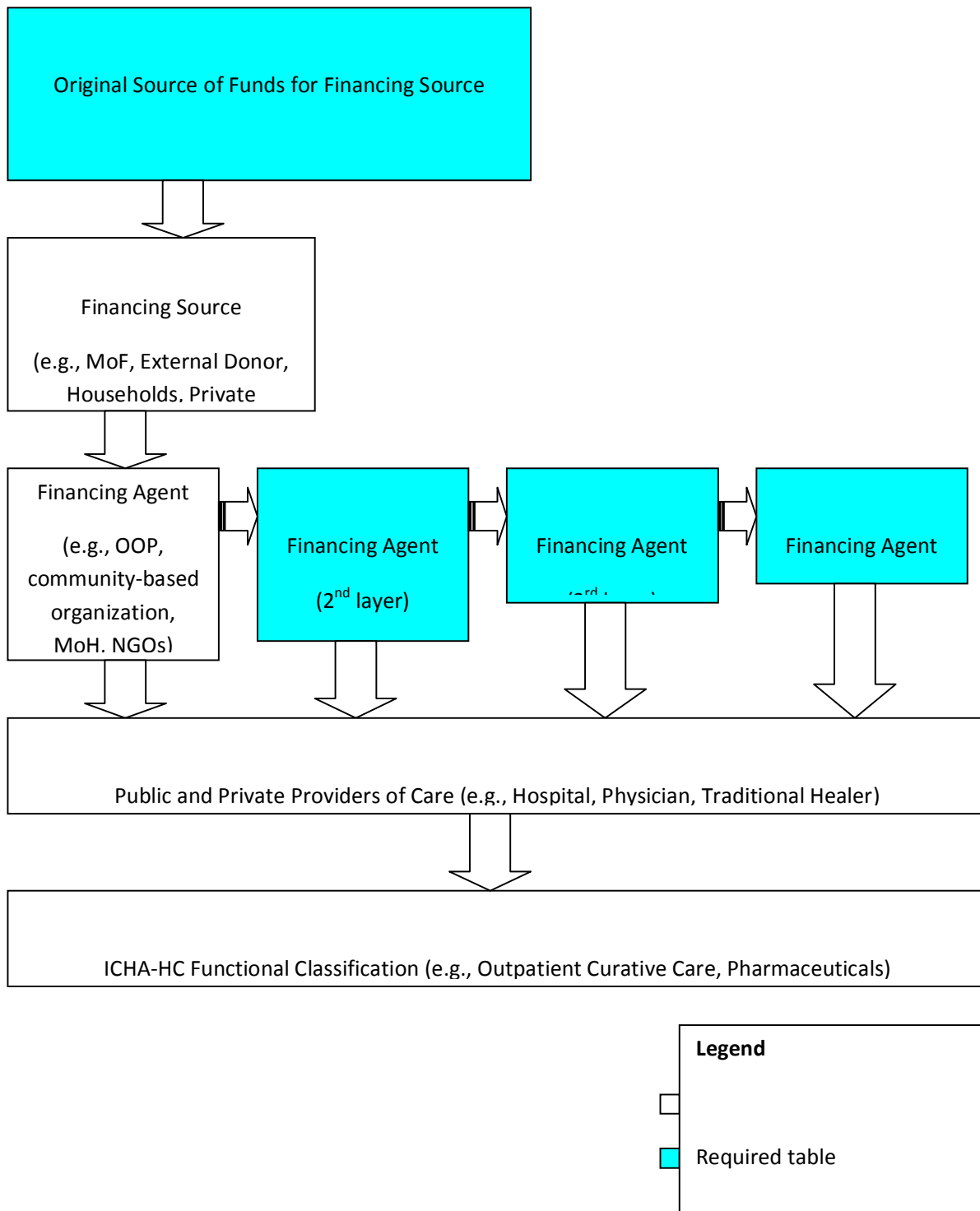
Next, the flow of funds should include financing agents that pay for the provision of health care services. These will include out-of-pocket payers, private sources (NGOs, private insurance), and public sources (MoH, local/district agents). Sometimes a financing source may also be the financing agent if it pays a provider directly. A distinction between financing agents and those financing sources that pay providers directly must be made clear. Essentially, this model is followed in the NHA *Producers’ Guide*. Additionally, funds may pass between multiple financing agents before reaching health care providers. Thus, a revised flow-of-funds framework should allow for multiple levels of financing agents. These optional tables would show the intermediate transfer of funds that takes place before funding ultimately reaches providers. Currently, many countries arbitrarily assign a single financing agent to account for money (based on general perceptions of which entity has programmatic control over resource

allocation) that passes between multiple levels of financing agents, ignoring the compounding administrative costs that are incurred in a multi-layer financing agent system. Awareness of these inefficiencies would be of utmost importance to policymakers and foster greater accountability of both government and donor funds.

After accounting for the final financing agent, the flow of funds framework should offer guidance for countries wishing to break providers down by ownership, in addition to by provider level (e.g., referral, district hospital). Basic ownership could be accounted for either as public, private (not traditional), or traditional. It would also be useful for policymakers to know whether providers are for-profit or not-for-profit. Tracking the growth of private providers would be a valuable tool for policymakers in low- and middle-income countries.

Though it will be discussed more in depth in Unit 7, most low- and middle-income countries may have difficulties completing the full functional classification as it currently stands. Many countries will be able to account for a limited set of functions, which may include curative inpatient care, curative outpatient care, pharmaceuticals, preventive public health programs, administration/stewardship, as well as non-personal health functions such as investments, training, and research. Training is particularly relevant to policymakers because it is a large expense in low- and middle-income countries. An understanding of the level of personal care expenditures on prevention (currently embedded in curative care) is another critical policy concern.

FIGURE 1



1.8 DEFINITIONS OF BOUNDARIES, CLASSIFICATIONS, AND OTHER GENERAL RECOMMENDATIONS

A selection of specific issues that require guidance are presented below:

1) The SHA 2.0 should include target tables, including optional tables for transfers between financing agents and to understand the “source of the source.”

2) Guidance is needed on how to implement boundaries, for example, how to convert from cash to accrual (as SHA recommends), or how to exclude health spending on expats at the provider level. In this respect, it would be useful for the SHA 2.0 to be not just a classifications document but also a practical “how to implement” manual.

3) Better guidance on how to classify state-owned enterprises also is needed. In some countries, the enterprises are considered largely public; in others (depending on the degree of autonomy), they are considered private.

4) Further clarification is needed for why HF.2.1.1 Government employee insurance programs are classified as HF.2 Private sector. In the System of National Accounts (SNA) and in the SHA, activities in which governments act in a fashion similar to private firms are classified as private activities. However, some policymakers may prefer to include this spending with other government spending for health. One suggestion may be to introduce the concept of a public sector and nonpublic sector to the International Classification of Health Account (ICHA)-HF scheme (see *Producers’ Guide* 4.07-4.09).

5) There is a need to clarify what constitutes Non Profit Institutions Serving Households (NPISH) both at the financing source and financing agent level. At the source level, it is taken to mean local foundation/NGOs that generate their own resources for health. At the agent level, it is often not clear how to classify implementing agencies (nongovernment), which can be private for-profit firms, not-for-profit firms, or international NGOs that may receive funds from donors locally in addition to generating their own funds (e.g., World Vision, Clinton Foundation); with respect to the last, clarification is needed to determine if they are donors or NPISH. Criteria are needed to better differentiate between a donor and NPISH at the agent level.

6) It should be clarified that loans are FS.1 General government (or whatever entity is responsible for repayment), whereas grants should be categorized in the financing sources dimension as Rest of world funds (FS.3), as in the *Producers’ Guide*.

7) Guidance is needed on how to treat medical savings accounts. Employers consider that a health expense occurs the year of the transfer of funds, but those funds may not be used to purchase health services until later. This issue needs to be explicitly addressed, both in terms of classification and how to capture it, because the use of medical savings accounts is expanding.

8) In-kind payments as well as informal payments by households should be explicitly discussed for developing countries.

9) The need to clearly define and possibly rename HP.5/HP.6 and HP.6/HP.7 is very important, because both category names include the word "administration." This has led policymakers in some countries to combine these costs and assert that administrative costs are too high. Either a clear distinction must be made between what SHA calls administrative costs as opposed to what policymakers, health accountants, and health economists refer to as merely indirect health care costs, or a health care category for pure administrative costs that exclude direct health care costs such as clinical staff time must be created. (This would require teasing out administrative costs that are embedded in curative and preventive functions.) Another suggestion to prevent confusion is to change HP.5 to Provision of Public Health Programs; HP.6 General health administration and insurance should also be renamed to distinguish it from HC.7 Health administration and insurance. This can be accomplished by adding "providers" to the health provider classification name.

10) Harmonize SHA and *Producers' Guide* classifications of traditional medicine providers. The category currently is listed as HP3.3 in SHA and HP3.9.3 in the *Producers' Guide*.

11) HP.3.4.5 All other outpatient multi-specialty and cooperative service centers and HP.3.4.9 All other outpatient community and other integrated care centers should be more easily distinguishable. Low- and middle-income country health centers have been alternatively classified as one or the other due to the lack of a clear definition. Health centers in low- and middle-income countries may be staffed by one person who is rarely a specialist, but serves multiple purposes.

12) Separate the stewardship function (and name it as such) from the function of managing insurance schemes.

13) In the developing world, public sector physicians sometimes work in the private sector in the evenings. How should this be accounted for?

14) Discussion is needed to determine whether gross domestic product (GDP) or gross national product (GNP) is better to use as the denominator when measuring the proportion of health expenditure and why.

15) While there has been work in the past to develop software to make the NHA process more user-friendly, some countries would like to see these efforts continued to more easily link the four dimensions of the flow-of-funds model.