GUIDELINES FOR THE IMPLEMENTATION OF THE SHA 2011 FRAMEWORK FOR ACCOUNTING HEALTH CARE FINANCING

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DISCLAIMER

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EXECUTIVE SUMMARY

Background and purpose

6. Health financing systems have undergone considerable change over recent decades. Better mobilisation and allocation of the resources necessary to meet current and future health needs of the population has led countries to introduce new mechanisms for the raising, pooling and purchasing functions, as well as more innovative institutional arrangements. The aim of any accounting framework is to mirror such structures, enabling health accountants and analysts to obtain a clear picture of health care financing and provide policy-relevant information concerning the structure and flows of funds. Resulting indicators – comparable both across countries and over time – can contribute to an assessment of how health care financing systems ultimately perform. In this sense, the new financing framework under *A System of Health Accounts 2011* can be regarded as bringing the statistics in line to meet the changing reality.

7. The **accounting framework for health care financing** is a key component of *A System of Health Accounts 2011*, published by OECD, Eurostat and WHO in October 2011.[1] The framework makes health accounts more adaptable to rapidly evolving health financing systems, further enhances cross-country comparability of health expenditures and financing data, and ultimately improves the information base for the analytical use of national health accounts (NHAs). It is hoped that SHA 2011 – including its financing framework – will make health accounts a more useful assessment and monitoring tool for health systems and health expenditure in the economy as a whole.

8. The framework provides an approach that better reflects the complex and changing systems of health care financing, eliminates ambiguities regarding some of the financing categories in SHA 1.0, provides new approaches for country-specific analysis and is sufficiently flexible to accommodate future changes. The framework also allows middle and low-income countries to provide a more transparent picture regarding foreign assistance.

9. The **SHA 2011 Financing Guidelines** ("Guidelines") provide a more detailed explanation of the various concepts, particularly concerning the role of the government in the health sector and foreign aid.[2] Furthermore, the Guidelines provide some practical approaches for preparing SHA data relevant to health care financing, together with possible methodologies that may be useful in the case of complex financing arrangements. Finally, they include a set of tools that health accountants can choose from, according to their specific needs.

10. The Guidelines serve as a basis for further developmental work. This work is considered as an iterative exercise comprising a number of steps and as a collaborative effort between the international organisations and experts in member countries.

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[1] Two important steps to harmonise information on financial flows related to health care were made in the early 2000s: the publication of "*A System of Health Accounts*" (SHA 1.0) by the OECD in 2000, including the International Classification of Health Accounts (ICHA); and the "*Guide to producing national health accounts with special applications for low-income and middle-income countries*" published as a combined effort of WHO, World Bank and USAID. As a next step, a joint health accounts data collection by the OECD, Eurostat and WHO started in 2005.

[2] Household OOP payments constitute the main component of spending in many lower and middle income countries. Guidelines are already available for the estimation of private expenditure (see Rannan-Eliya and Lorenzoni, 2010),.

11. It is not expected that a country will implement all elements of the Guidelines. Differences in the complexity of health financing systems, health policy priorities, data availability and resources will all influence a country's choice. As the Guidelines are used, they are also likely to raise further issues and provide solutions for some of the outstanding problems already addressed in this version.

Financing schemes at the core of a new approach

12. The aim of the SHA financing framework is to provide a clear picture of the structure and flows (transactions) of a country's health financing system. Comprehensive accounting of these flows requires tools to track the revenue-raising, pooling and resource-allocation of funds, as well as the institutional units involved. SHA 2011 puts financing schemes at the core of the financing framework, making a clear distinction from the agents (institutional units) administering the schemes.

13. Health care financing schemes are the basic components of health financing systems; they are the main types of financing arrangements through which people obtain health services. Health financing schemes include both direct payments by households as well as third-party financing arrangements. The latter consist of a distinct body of rules governing the mode of participation, the basis for entitlement to health services and the rules on raising and pooling the revenues, as well as the payment mechanisms, of the given scheme.

14. The role of financing schemes reflects the key societal function of health care financing. For example, sub-categories of Government and compulsory contributory schemes (HF.1) aim at ensuring access to basic health care for the whole society or a large part of society, while voluntary schemes (HF.2) provide access to care based primarily on the discretion of private actors. The SHA 2011 financing framework is able to compare increasingly complex health financing arrangements encompassing a mix of publicly and privately regulated revenues, financing schemes with compulsory or voluntary participation that are in turn operated by a mix of publicly and privately owned institutions.

15. The central role of financing schemes, however, does not mean that the institutional settings around resource allocation and revenue-raising are not important. The retention of a Classification of Financing Agents (ICHA-FA) in the framework can help address these issues.

16. Concerning revenue-raising, data on revenues of financing schemes provide information on: (i) how much revenue is collected and (ii) in what ways is it collected for type of financing scheme. Information on which institutional units of the economy are providing revenues for each type of financing scheme can also be analysed.[3]

17. In summary, the SHA 2011 financing framework increases the transparency of health financing systems, creating the possibility to monitor changes, compare health expenditures across countries and over time, as well as providing better information for analysis of the performance of health care financing systems. This is due to the clear distinction between the following four elements: financing schemes (e.g., social insurance, etc.), financing agents managing the schemes (e.g., government unit and private insurance companies, etc.); revenues of each scheme (e.g., insurance contributions and transfers from government, etc.) and the institutional units providing those revenues (households, corporations and government).

[3] Using the Reporting Items of the Classification of Revenues of Health Care Financing Schemes (FS.RI).

INTRODUCTION

Background

18. In 2007, OECD, Eurostat and WHO started collaborating on methodological developmental work towards a common revised manual of the System of Health Accounts (SHA). The revision process was completed in October 2011, with the publication of *A System of Health Accounts 2011*.

19. The SHA 2011 Financing Guidelines[4] present the overall financing framework with some important elements covered in detail. Further development of the Guidelines is considered an iterative and collaborative effort.

20. The development of the Guidelines has been a collaborative project with the WHO NHA Team and other experts. Interim versions of the Guidelines were discussed at the 2011 and 2012 OECD Meetings of Health Accounts Experts, as well as at the Technical Workshop on the Implementation of the Health Financial Framework under SHA 2011 (9 October 2012).

Purpose of the Guidelines

21. The aim of the Guidelines is to help health accountants compile SHA data related to health financing for national and international reporting and to provide additional health accounting tools for a more detailed analysis of a country's health financing system.

Scope

22. The Guidelines are primarily concerned with describing the financing of final consumption of health care services and goods. While *A System of Health Accounts 2011* also covers the accounting of capital formation in health systems, the Guidelines do not deal specifically with this aspect. The Guidelines include clarification and complementary definitions, quantitative examples and specific accounting procedures linked to the systematic classification of transactions. Issues of data sources and estimation methods are addressed under the relevant chapters.[5]

Sources

23. The preparation of the Guidelines has taken into consideration the knowledge in health accounting practice accumulated over the past decade or so, as well as relevant literature on health care financing. Some of the lessons learnt from country examples on the implementation feasibility of SHA 2011 have also been considered.

How to use the Guidelines

24. The Guidelines complement the relevant chapters of the SHA 2011 Manual (Chapters 7 and 8 and Annex D). As a stand-alone document they do necessitate the repetition of some parts of the Manual. However, the Guidelines provide a more detailed explanation of the changes in concepts and specific aspects from which health accountants can choose according to their specific needs. It is not expected that

[4] Referred to as the Guidelines.

[5] Since guidelines are already available for the estimation of private expenditure (Rannan-Eliya and Lorenzoni, 2010), these Guidelines do not deal with this issue specifically.

a country will need to refer to all elements of the Guidelines. Differences in the complexity of health financing systems, health policy priorities, data availability and available resources will all influence a country's choice among the various approaches provided by the Guidelines.

25. In the interests of practical use, numerical examples are provided in the main text of the Guidelines. Experience when implementing the Guidelines is likely to raise further issues or provide new solutions for technical problems already addressed.

Structure of the Guidelines

26. The Guidelines consist of the following chapters and annexes:

1. **An overview of accounting of health care financing under SHA 2011**
   A brief overview of the elements of a comprehensive accounting of health care financing: the outputs and links to policy analysis if a country applied all the elements provided by SHA 2011 for accounting of health financing?

2. **Description of the health care financing system from a health accounting point of view**
   Guidance on identifying health care financing schemes, financing agents and revenues of the health care financing schemes in a given health system.

3. **Mapping from SHA 1.0 to SHA 2011**
   Provides an explanation of the conceptual change from institutional units to financing schemes, and the revenues of those schemes. Practical guidance is provided for mapping previous categories of health financing to categories of health care financing schemes and revenues of health care financing schemes.

4. **Accounting the government's involvement in health care financing**
   Guidance for distinguishing and accounting the different roles of the government from a functional and institutional point of view: (i) the collecting-pooling-redistributing and purchasing functions of government; and (ii) government as a provider of revenues, a financing agent, in addition to being owners of health care provider institutions.

5. **Interpretation of "public" and "private" under SHA 2011**
   An interpretation of "public" and "private" finance under SHA 2011, a practical accounting guidance to prepare expenditure aggregates, as well as a discussion of some specific accounting issues related to the public-private mix in health systems (e.g., cost-sharing).

6. **Accounting foreign aid**
   A comprehensive description of foreign involvement in health care financing and an explanation of the correspondence between SHA 2011 and international aid statistics.

7. **Accounting health care financing from the perspective of individual schemes and institutional units**
   This chapter provides two related tools: a possible way to show the relationships between FS, HF and FA in the case of a particular financing scheme; and examples of sectoral accounts (expenses and revenues for types of financing schemes and institutional units)[6].

[6] The term "sectoral accounts" is used to show the expenses and revenues of the individual financing schemes or individual institutional units in a T-account format.

Annex 1 briefly describes the different tables that can be created from an SHA 2011-based health accounts database relevant to health care financing and their analytical use.

Annex 2 presents the three classifications related to health financing (that is, classification of financing schemes, revenues of financing schemes and financing agents) and some basic tables and charts from the SHA 2011 Manual and referred to in the Guidelines.

CHAPTER 1: OVERVIEW OF ACCOUNTING OF HEALTH FINANCING UNDER SHA 2011

Chapter 1 presents a brief overview of the elements of a comprehensive accounting of health care financing. In essence, it gives an idea of the outputs if a country applied all the available tools under SHA 2011 for the accounting of health financing.

27. Although the Guidelines are expected to be used in conjunction with the SHA 2011 Manual, some sections of Chapter 7 and Chapter 8 from the manual are repeated here to provide the context.

The elements of the accounting framework for health care financing

28. The accounting framework for health care financing consists of the following:

- Key concepts and definitions;
- A set of classifications (SHA 2011: Chapter 7 and 8 and Annex D);
- A set of accounts: a simplified representation of flows of financial resources in the health care system (SHA 2011: Chapter 15 and Annex D);
- A set of key indicators;
- An optional set of sectoral accounts focusing on specific health financing schemes and institutional units (SHA 2011: Annex D).

29. Implementation of the SHA 2011 financing framework by a country requires:

- An institutional setting for the regular production of the Health Accounts (HAs);
- National database(s);
- Documentation of the production procedures and methodologies;
- Methodological notes on any deviations from the SHA 2011 concepts and definitions;
- Procedures for monitoring and reviewing the HAs and for setting a plan (priorities) for further development.

Key concepts

30. The framework for health care financing under SHA 2011 does not intend to show the *whole* complexity and *all* details of a health financing system. Instead, it focuses on the most important issues from the perspective of accounting for health expenditure.

31. The key concepts for describing the structure (institutions) and transactions (flows) of the financing system under SHA 2011 are as follows:

- **Health financing schemes** as the main "building blocks" of a country's health financing system (covering the financing arrangements of revenue collection, pooling and entitlement up to the payment of health services for and on behalf of the population). For example, direct payments by

households or third-party financing arrangements, such as social health insurance, voluntary insurance, etc.[7]

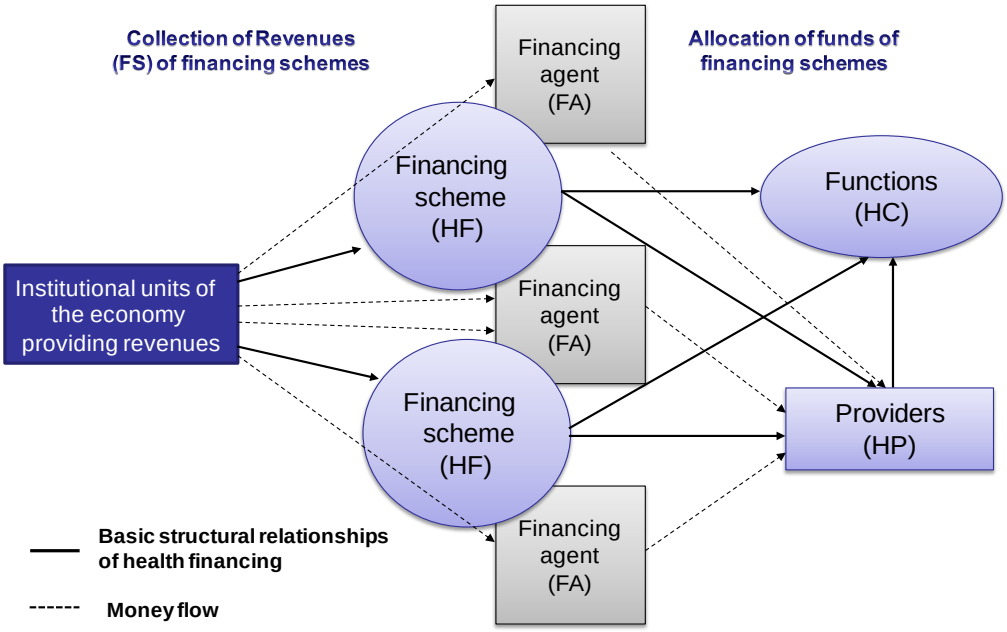
- **Types of revenues** of health financing schemes as the approach to identify, classify and measure the mix of revenue sources for each financing scheme (for example, social security contributions used to fund the purchases by social security schemes, etc.).

- **Institutional units** of health care systems (such as government, households and insurance corporations, etc.) manage the various functions in the health system: collecting, pooling, redistributing, paying and providing services directly. **Financing agents** are institutional units that administer health financing schemes in practice: implement the revenue-collection and the purchasing of services. For example, local government, social insurance agencies, private insurance companies, non-profit organisations and so on. (A financing agent can manage one or more financing schemes at the same time.)

Graphical representation of the SHA 2011 financing framework

32. Figures 1.1 and 1.2 show a generic and a more detailed and specific representation of the SHA 2011 financing framework.[8] It is suggested that a country implementing the Guidelines should construct a diagram similar to Figure 1.2 for their own health financing system.

Figure 1.1 A graphical representation of the SHA 2011 financing framework (version 1)



Source: (SHA 2011)

33. The left-hand side of Figure 1.2 shows the main primary owners of income: employers, households and the rest of the world (RoW). Government and certain NGOs – collecting and redistributing income from the primary owners of income - are also considered providers of revenues for financing schemes. The right-hand side of the figure shows the main types of financing schemes and financing agents managing the purchasing function of the schemes (i.e. paying the providers).

[7] The main concepts and criteria for defining and distinguishing schemes can be found in Chapter 7 of SHA 2011.

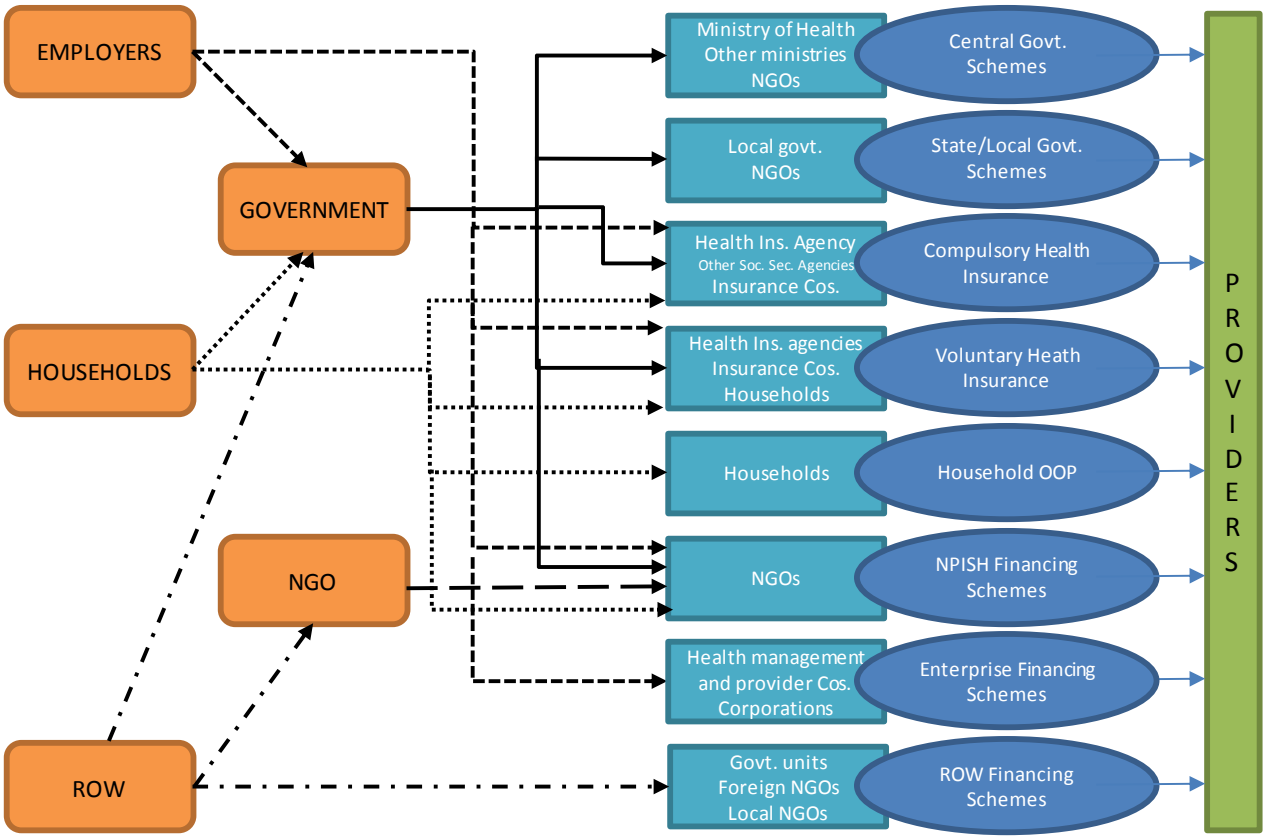
[8] Figure 1.1 is the same as Figure 7.1 in SHA 2011.

34. The main differences between Figures 1.1 and 1.2 are that the latter:

- focuses on the revenue-raising of financing schemes, showing the special role of the government and some NGOs in the secondary distribution of financial resources;
- provides the main categories of financing schemes with examples of their typical financing agents;

35. Figure 1.2 is intended to guide countries in preparing a graphical representation of their own SHA 2011-based financing framework. Health accountants can decide which elements are relevant for their country and what important country-specific elements should be added.

Figure 1.2 An example of a country's health financing system under SHA 2011 framework



36. A clear distinction should be made between the concepts adopted to analyse the financing of the consumption of health services and goods, and the data collection processes. **Health care financing schemes (HF)** are the key units for the **analysis** of financing of health care services and goods, while the **data** concerning the relevant transactions may be collected **either from financing agents** operating the different financing schemes (including institutional units collecting the funds, if they are different form agents paying the providers) **or from the providers**, depending on a country's statistical system. To put it another way: the categories of health financing schemes are the key analytical units, determining which data are collected from financing agents or providers.

37. Figures 1.1 and 1.2 indicate that the financial flows are administered (i.e. revenues are collected and expenditures are spent) by the financing agents (under the rules of the given financing schemes).

38. Health accounts data provide information on:

- *How the funds of particular health financing schemes are allocated:*
    - Under each financing scheme, which services are purchased on behalf of individuals or the community as a whole, and from which providers;
    - What institutional units are managing the purchase of services under each type of financing schemes?
- *How the revenues of particular health financing schemes are raised:*
    - Under what mechanisms do financing schemes collect their revenues?
    - From which institutional units of the economy are the revenues of a particular financing scheme mobilised?

39. In a simple health financing system there may be a one-to-one correspondence between the revenue, the scheme and the agent. For example, a country's National Health Service may only be financed from general government revenues and operated by government units. However, this is not typically the case. A financing scheme will tend to raise its revenues from several sources and may be operated by more than one type of institutional unit (financing agents). For example, social health insurance may raise its revenues not only from contribution payments by employees and employers, but also from transfers from the general government budget. Furthermore, a social health insurance scheme may be operated by a government unit and private insurance companies at the same time.[9]

40. Table 1.1 summarises the key advantages of the SHA 2011 financing framework from a health policy perspective, including a more accurate interpretation of "public" and "private", which is explained in further detail in Chapter 4.

Accounting tools provided by the Financing Guidelines

41. The accounting concepts and tools provided by SHA 2011 offer the opportunity – if a country requires - to track money flows[10] in a more detailed way than simply using cross-classified tables. For example, health accountants and analysts may be interested in a comprehensive picture of the government's health-specific revenues and spending, including capital formation, health-related functions, etc.). The revenue-raising by financing schemes (FSxHF) is, in many cases, the last stage of the revenue-collection flow and such a report may show, for example, that the social insurance scheme receives some revenues from the government. However, the first stage of the revenue-collection flow is the government's collection of taxes and other revenues from primary owners of income. Health accountants and analysts may be interested in studying the overall burden of health care financing on the primary owners of income, in particular on households.

[9] In a few countries (e.g. the Netherlands, the Slovak Republic, Switzerland, etc.), decisions already had to be made about whether to apply a financing scheme or an institutional approach. The countries applied a financing scheme approach to more accurately reflect their financing systems characteristics. (In a strict sense, however, there was a discrepancy between the definitions under SHA 1.0 and the new schemes.)

[10] For simplicity, the terms 'money flow' or 'financial flow' are used, although health accounts also include all relevant transactions in kind.

Table 1.1 The key characteristics of the SHA financing framework from a health policy perspective

Characteristics of the SHA 2011 financing framework	Issues of policy analysis supported by the SHA 2011 financing framework
The framework is based on the concept of the 'financing scheme'. It interprets financing schemes (HF) as the basic components of the health financing system, and hence connects them to health care providers and functions in the tri-axial system of the SHA.	How much is spent and on what by scheme, based on the principle of equal access to care (regardless of the institutional arrangements), and how much is spent according to ability to pay? What kinds of services are ensured (purchased) under the different financing schemes? How are the particular health care services or goods financed? For example, what share of spending on in-patient care is covered by compulsory insurance, voluntary insurance and out of pocket (OOP) payments? What kinds of services are ensured (purchased) under the different financing schemes? How are the resources of the different financing schemes allocated among the different services?
A distinction is made between the financing schemes (HF) and the institutional units (financing agents: FA) that manage them, clarifying the relationship between them	How is health financing managed in a country? What kind of institutional arrangement is used to govern the funds of health financing schemes? What changes have occurred in the institutional arrangement of health financing over a given period? It allows the monitoring of changes in the institutional arrangements of a financing scheme (e.g., compulsory insurance) and the possible effects of institutional reform on the balance of a given scheme (complemented with other information). It provides the possibility to compare the administrative costs of different institutional arrangements of a given financing scheme.
The framework changes the focus from "financing sources" as institutions to types of revenues of the health financing schemes (transactions of revenue-raising).	This allows an analysis of (i) the main mechanisms (and their changes over time) of revenue-collection; (ii) the structure of and changes in the revenues of health finance; (iii)the balance of revenues and spending of each financing scheme. On the other hand, keeping information on the institutions providing revenues also allows an analysis of how the burden of health care financing is distributed across institutional units of the economy, and therefore the public-private split.
The framework provides a distinction between the different roles that institutional units, such as government and households, play in a health system.	A deeper analysis of the government's role in health financing is possible by separating: (i) transactions by governmental financing schemes (revenue-raising, pooling and purchasing; (ii) the provision of revenues by the government to other health financing schemes; (iii) non-health spending by the government units acting as health financing agents.
The framework shows the relationships (i) among the institutional units providing revenues, the types of revenues and the financing schemes; (ii) among financing schemes and financing agents; (iii) among financing schemes, financing agents and health care providers; (iv) among financing schemes, financing agents and health care functions;	It allows a detailed country-specific analysis of transactions of functions of financing: revenue-collection, pooling (redistribution) and purchasing concerning both the whole health financing system and concerning each financing scheme.
The framework allows the possibility to prepare sectoral accounts for the most important financing schemes or financing agents.	A detailed country-specific analysis of the fiscal balance of the main financing schemes and/or agents is possible.

CHAPTER 2: DESCRIBING THE HEALTH CARE FINANCING SYSTEM

This chapter details the process towards a **qualitative description** and analysis of a country's health financing system, consisting of the following main components: (i) identification of the health financing schemes; (ii) description of the functional and institutional structure of the health financing system (financing schemes and related financing agents); and (iii) identification of the basic flows in health financing: revenue-raising by the financing schemes and allocation of resources by the financing schemes (according to functions, providers and beneficiaries).

General description

42. The structure of a health financing system consists of two components: financing schemes (e.g., National Health Service, social health insurance and voluntary insurance) and the institutional units (or financing agents, e.g., government units, social security agency, private insurance corporations) operating the financing schemes.

43. The operation of a health financing system entails transactions related to the three main functions of health financing: revenue-raising, pooling and purchasing - e.g., the payment of social insurance contributions to a single national fund, distribution of the resources first among the different purchasing funds and then according to the services and their providers. The transactions are executed between institutional units, **according to the rules of the financing scheme**. The general description of a given health financing system includes – among others – the identification of these elements (i.e., financing schemes, their transactions and the institutional units involved in the transactions). There are three main types of institutional units: revenue providers (e.g., enterprises, households), the financing agents (covering organisations collecting and/or pooling revenues and/or paying for services), and the providers of health care (services and goods).

44. The key tasks to provide a general description of a financing system from a health accounting point of view are as follows:

- Task 1: Identification of the national health care financing schemes (an inventory of schemes with basic information on mode of participation, benefit entitlement, as well as fund raising and pooling mechanisms. Information on the benefit package can also be of use);

- Task 2: Applying the structure of the health financing system (Financing schemes and related financing agents);

- Task 3: Identification of the basic flows in health financing: (i) revenue-raising by the financing schemes and (ii) allocation of resources by the financing schemes (according to functions, providers and beneficiaries).

45. To complete these tasks requires some important initial background information. First of all, a clear delimitation of the health care system with respect to any deviations between SHA 2011 and national boundaries (for example, in the areas of LTC and prevention activities) is required (See SHA 2011: Chapter 4).

46. In describing the health financing system, it may be useful to prepare a chart (e.g., similar to Figure 1.2) showing a graphical representation of the health financing system of the given country.

47. The ultimate aim should be to develop a database of the transactions linking together the financing schemes with the agents and revenues. This can then be linked to database(s) on the resource allocation by the financing schemes according to the providers, functions, etc. The various cross-classified tables can then be extracted and compiled for analytical and presentational purposes.

Task 1: Identification of the national health care financing schemes

48. The starting point should be a qualitative analysis of all of the national schemes within the country's health financing system, and then, using the table of main criteria and the decision tree, each scheme should be classified according to the SHA 2011 Classification of Financing Schemes (HF) based on the definitions of the HF categories. (See Annex 2)

49. Therefore, we need first to identify all the financing arrangements (schemes) of a country together with their main characteristics. One approach may be as follows:

- First, list the national schemes together with information on the mode of participation, benefit entitlement, as well as the benefit package which can be used to help classify each scheme. It is important that all financing schemes that purchase health care goods and services for residents of the country are included. At this stage, it may be necessary to detail sub-schemes which have very specific financing and payment strategies e.g. for particular treatments for sub-populations.

- For each financing scheme listed, the following questions should then be asked: (i) does the scheme fit one of the categories of the HF classification given the list of characteristics? and (ii) should any of the sub-schemes warrant country-specific sub-categories to be added to the HF categories (for later analytical purposes)?

- The next step is to determine whether any of the health care financing arrangements cannot be easily categorised according to one of the HF categories. The use of the decision tree (Annex 2) can be very useful at this stage. The following section provides a non-exhaustive list of possible issues.[11]

50. Table 2.1 provides a simplified example of the identification of health financing schemes together with some accompanying explanatory notes.

Selected issues connected to the identification of financing schemes

51. In identifying the financing schemes present in a country, health accountants should determine whether there are any health care financing arrangements that cannot be easily placed under any of the HF categories. Depending on the problem, health accountants may find a solution by compiling additional information on the scheme in conjunction with the criteria tree, or through some of the subsequent chapters of these Guidelines (e.g. Chapter 4 on the various roles of government in health care financing), or by consulting further with health financing experts within government health care administration or other relevant institutions. The following sections provide some examples of the more common issues.

[11] Another possible approach for a country with a relatively simple institutional setting of its health system and experience in producing SHA 1.0-based NHAs is to include in the table the categories of HF used previously to the categories of Financing Schemes under SHA 2011. This approach is presented in Chapter 3.

Table 2.1 Description of the health financing system: List of health financing schemes in COUNTRY (A)

Health care financing activity	Participation and benefit entitlement	Benefit package	HF Code	Sub-code (a)	HF description
Health system administration and governance	Health system administration is considered a service provided to the whole population	All public administration activities needed to operate the health system, including imputed costs of collecting the central government general revenues used for the health system	HF.1.1.1		Central governmental schemes
Central govt. financing of public health activities	All permanent residents	National prevention programmes and epidemiological surveillance and disease control activities	HF.1.1.1	*HF.1.1.1.1*	Central governmental schemes
Central govt. financing of National Emergency Service	All permanent residents	Emergency ambulance care that does not include care in hospitals. NAS does not provide non-emergency transport.	HF.1.1.1	*HF.1.1.1.2*	Central governmental schemes
Health care scheme for govt. employees	Employees in central and local public administration and their family members	A wide range of health services and medical goods with cost sharing on part of the medical goods	HF.1.1.1	*HF.1.1.1.3*	Central governmental schemes
Health care scheme for army personnel	Employees of the army and their family members	Health services provided in the health care institutions of the army and medical goods with cost sharing on part of the medical goods	HF.1.1.1	*HF.1.1.1.4*	Central governmental schemes
Contribution to operating costs of state-owned health care providers	Considered a benefit for all residents, as public hospitals have a contract with all the insurance schemes	Contribution to operating costs of hospitals owned by the county governments	HF.1.1.2	*HF.1.1.2.1 (b)*	State/regional/local governmental schemes
Statutory social health insurance (SHI)	Population with per capita household income below a threshold	A wide range of health services and medical goods with cost sharing on both the services and the medical goods	HF.1.2.1		Social health insurance schemes
Compulsory private health insurance policies	Individuals with a per capita household income above a threshold	A wide range of health services and medical goods with cost sharing on both the services and the medical goods	HF.1.2.2	*HF.1.2.2.1*	Compulsory private insurance schemes
Statutory long-term care insurance scheme (c)	All permanent residents above the age of 30	LTC services	HF.1.2.1	*HF.1.2.1.2*	Social health insurance schemes
Voluntary health insurance policies	Individuals who buy voluntary health insurance	Various insurance policies covering the cost-of services (with or without cost-sharing from the patient) that are not included in the package of compulsory health insurance schemes	HF.2.1.2		Complementary/supplementary insurance schemes
NGO health programme for drug addicts			HF.2.2		NPISHs financing schemes
Employers' occupational health schemes			HF.2.3		Enterprises' financing schemes
Payments by households			HF.3		Household out-of-pocket payments
Etc., ...			...		...

Notes:

(a) It may be appropriate to use country-specific sub-categories of HF. For example, this can be very relevant for governmental financing schemes.

(b) Contribution to operating costs of health care providers owned by the state/regional/local government is considered a governmental financing scheme. For example, local government may pay the utility costs of GPs while GP services are paid by the social health insurance scheme.

(c) The categorisation of statutory LTC insurance operated by private health insurance companies requires further analysis.

Separating Social health insurance schemes (HF.1.2.1) from Compulsory private insurance schemes (HF.1.2.2)

52. Take the example of a particular country that runs a compulsory LTC insurance which is administered by private insurance companies. (Note that under SHA 1.0 this was categorised under HF.2 Private sector as HF.2.1. Private social insurance.)

53. Since a contribution payment is requested by law, the scheme is considered as a compulsory contributory health financing scheme. Under SHA 2011 all compulsory schemes are accounted for under HF.1 Governmental schemes and compulsory contributory health financing schemes. However, ambiguity remains regarding the appropriate sub-category: whether this LTC scheme should be accounted as a Social health insurance scheme (HF.1.2.1) or a Compulsory private insurance scheme (HF.1.2.2). To be able to categorise further, health accountants need to gather additional information on the contribution mechanism and the relationship between the individual and the private insurer. Using the table of definitions together with the criteria tree, it can be seen that the distinction between the two rests on determining whether there is the *purchase* of a contract between the individual and the insurance company.

"Automatic" mode of participation

54. Mode of participation is one of the criteria for classifying financing schemes and refers to the relationship between the individuals and the financing scheme. The SHA 2011 concept of compulsory (mandatory) participation may not always be clear, particularly in the case of government schemes whereby the mode of participation is 'automatic'. In the case of social health insurance or compulsory private insurance it is relatively straightforward in that participation (contribution payment) is mandatory by law for all the population or for defined groups within the population. However, in the case of government financing schemes such as a national health service or particular programmes for certain groups of the population, or collective services, it is considered that coverage for all (or groups) of the population is 'automatic' (and, in this sense, compulsory), irrespective of whether they use the services or not.

55. In the case where employees are 'obliged' to enrol automatically into their company's health insurance scheme, this is not compulsory *by law* or regulated by government, and as such is still considered as discretionary, and therefore would be classified as a voluntary scheme. Note, this is not restricted to private corporations, since if public corporations enrol their employees in a voluntary health insurance scheme this is still a discretionary use of public resources, not compulsory by law or regulated by government, and therefore should still be considered as a voluntary scheme.

Separate schemes for government employees

56. Government employees may have a separate arrangement; government may provide specific health programmes for its employees. In some countries, the government reimburses its employees' health care bills and pays for their care while abroad. Such cases should be accounted for as HF.1.1.1, and if the amount is policy relevant and/or significant, it may be useful to create specific sub-categories under governmental schemes, for example:

- HF.1.1.1.1 Central governmental schemes (excluding Government employees schemes)
- HF.1.1.1.2 Government employees' schemes

57. The financing agent (e.g., government unit, private insurance corporation, etc.) will show the exact institutional form of the given governmental employees' scheme.

58. However, as noted above, in the case when government simply buys group insurance on behalf of its employees, it should be treated as any other employer, and its classification as compulsory or voluntary dependent on law (or government regulation) (See Table 2.2).

59. Similarly, it is not necessary to distinguish between government (or public) employees and other (private sector) employees regarding participation in the general social insurance scheme; government pays the social insurance contribution in the same way as other employers.

Table 2.2 Accounting specific schemes for government employees

Description of health financing schemes for Government employees	Accounting under SHA 2011
The Government provides specific health programs for its employees. For example, a government unit directly pays for health care to the providers (or reimburses the bill submitted by the government employee).	HF.1.1.1 Governmental financing schemes (a specific sub-category for government employees might be appropriate in this case)
The Government *is obliged by law* to buy private group insurance for its employees from an insurance company (selecting from the insurance policies offered by the company generally as a primary coverage benefit package to individuals who are not entitled for SHI).	HF.1.2.2 Compulsory private insurance scheme

60. Table 2.3 provides a non-exhaustive check-list of some additional issues concerning the correct identification of health financing schemes. The following chapters provide more extensive guidance on some of those listed.

Table 2.3 Some additional issues concerning the identification of financing schemes

Classification of Health Financing Schemes		Specific issues
HF.1.1.1	Central governmental schemes	Make a distinction between specific government programmes and government acting as an employer. Identify government sub-schemes with targeted financing and payment strategies. Separate government schemes from other financing schemes which receive revenues from government. See Chapter 4.
HF.1.2.1	Social health insurance schemes	Make a distinction between Social health insurance (HF.1.2.1) and Compulsory private insurance (HF.1.2.2).
HF.1.2.2	Compulsory private insurance schemes	
HF.2.1	Voluntary health insurance schemes	Separate complementary or additional coverage under VHI schemes from other schemes administered by the same financing agent.
HF.2.2	NPISHs financing schemes	Distinguish between NPISHs financing schemes from governmental schemes operated by NPISHs (FA.4)
HF.3.1	Out-of-pocket excluding cost sharing	Exclude payments by patients covered by third-party financing scheme.
HF.3.2	Cost sharing with third-party payers	Consider separately household payments made under a cost-sharing arrangement with other compulsory or voluntary financing schemes.
HF.4	Rest of the world financing schemes (non resident)	Foreign-based insurance schemes providing services to residents either through domestic or foreign providers. Enclaves (embassies) providing health care to resident employees. See Chapter 5.

Task 2: Applying the institutional structure of the health financing system

61. Having identified all national financing schemes and allocated each according to the SHA 2011 HF classification, the next task is to identify the financing agent(s) administering the given financing schemes with an indication of the relevant data sources concerned.

62. As in the previous step, it is proposed to first make an inventory of all the institutional units performing the functions of revenue-collection and/or pooling and/or purchasing.

63. The next step is to further build up the database, adding the financing agents undertaking the purchasing function for the various financing schemes using the list of institutional units mentioned above. It should be clarified whether any additional institutional units are involved in the collection and/or pooling of the revenues for the financing scheme. If yes, this also should be indicated. This can be important in reconciling multiple data sources as well as clarifying any additional costs to the scheme (See Chapter 4). Table 2.4 provides an example, linking the financing schemes identified in the previous step with the financing agents responsible for the purchasing of health care goods and services under the scheme, as well as any additional institutions involved in the revenue-collecting and/or pooling functions. The purchasing agents are then classified according to the FA classification of financing agents.[12]

Identifying the most important differences between the classification of health financing under SHA 1.0 and SHA 2011[13]

64. If SHA 1.0-based health accounts have previously been produced, then the additional information (metadata) relating to the SHA 1.0 HF category can be added to the database at this stage. This helps to identify the most important differences between the classification of health financing under SHA 1.0 and the HF categories under SHA 2011 (See Table 2.3). This will also provide assistance in identifying the financing agents and categorising them according to the FA classification.

Example of compulsory insurance

65. In a particular country, the categorisation of a statutory insurance scheme under SHA 1.0 was dependent on the legal form of the institution operating the scheme. For example, statutory insurance operated by non-profit funds was classified under SHA 1.0 as HF.1.2: Social security funds. The same statutory insurance operated by private health insurance companies was classified as HF.2.1: Private social insurance.

66. However, since the only difference is the institutional setting for the administration of the scheme (i.e. individuals have the option with which institution they sign up), under SHA 2011 both are classified as HF.1.2.1 Social health insurance, but with different financing agents (FA.1.3.2 Other social security agencies and FA.2.1: Commercial insurance companies).

67. Table 2.5 presents the categorisation of the various compulsory insurance schemes under SHA 1.0 and SHA 2011.

[12] Annex A2 contains the SHA 2011 Classification of Financing Agents.

[13] Identification of financing schemes by mapping the Classifications of health financing (SHA 1.0) to Financing schemes (HF) under SHA 2010 is further discussed in Chapter 3.

Table 2.4 Structure of the health financing system: financing schemes and financing agents in COUNTRY (A)'s health system

Description	HF code	Sub-code	HF description	Collecting agent	Purchasing agent	FA code	FA description	Data source(s)
Health system administration and governance	HF.1.1.1		Central governmental schemes	Ministry of Finance	Ministry of Health	FA.1.1.1	Ministry of Health	MoH
Central govt. financing of public health activities	HF.1.1.1	*HF.1.1.1.1*	Central governmental schemes	Ministry of Finance	Ministry of Health	FA.1.1.1	Ministry of Health	MoH
Central govt. financing of National Emergency Service	HF.1.1.1	*HF.1.1.1.2*	Central governmental schemes	Ministry of Finance	Ministry of Health	FA.1.1.1	Ministry of Health	MoH
Health care scheme for govt. employees	HF.1.1.1	*HF.1.1.1.3*	Central governmental schemes	Ministry of Finance	Ministry of Interior	FA.1.1.2	Other ministries and public units	MoI
Health care scheme for army personnel	HF.1.1.1	*HF.1.1.1.4*	Central governmental schemes	Ministry of Finance	Ministry of Defence	FA.1.1.2	Other ministries and public units	MoD
Contribution to operating costs of state-owned health care providers	HF.1.1.2	*HF.1.1.2.1*	State/regional/local governmental schemes	State government	State government	FA.1.2	State/regional/local government	Sate govt.
Statutory social health insurance (SHI)	HF.1.2.1		Social health insurance schemes	National Health Fund	General regional funds	FA.1.3.1	Social Health Insurance Agency	NHF
					Industrial branch-based sickness funds	FA.2.2	Mutual and other non-profit insurance organisations	NHF
					Sickness funds for farmers	FA.2.2	Mutual and other non-profit insurance organisations	NHF
					Sickness funds for miners	FA.2.2	Mutual and other non-profit insurance organisations	NHF
					Retirement funds	FA.1.3.2	Other social security agency	NHF
Compulsory private health insurance policies	HF.1.2.2	*HF.1.2.2.1*	Compulsory private insurance schemes	Private insurance Co.	Private insurance Co.	FA.2.1	Commercial insurance companies	Association of insurers
Statutory long-term care insurance scheme	HF.1.2.2	*HF.1.2.2.2*	Social health insurance schemes	LTC fund	LTC funds	FA.1.3.2	Other social security agency	Association of insurers
				Private insurance Co.	Private insurance Co.	FA.2.1	Commercial insurance companies	
Voluntary health insurance policies	HF.2.1.2		Complementary/supplementary insurance schemes	Private insurance Co.	Private insurance Co.	FA.2.1	Commercial insurance companies	Association of insurers
NGO health programme for drug addicts	HF.2.2		NPISHs financing schemes	NGOs	NGOs	FA.4	NPISH	Survey
Employers' occupational health schemes	HF.2.3		Enterprises' financing schemes	Corporations	Corporations	FA.3	Corporations (other than insurance corporations)	Survey
Payments by households	HF.3		Household out-of-pocket payments	Households	Households	FA.5	Households	HBS
Etc….								

Table 2.5 Key differences between the classification of the health financing under SHA 1.0 and SHA 2011

Health insurance schemes	SHA 1.0		SHA 2011	
Compulsory insurance scheme *administered* by non-profit funds	HF.1.2	Social Security Funds	HF.1.2.1	Social health insurance
Compulsory insurance scheme *administered* by private health insurers	HF.2.1	Private social insurance		
Compulsory private health insurance (for individuals with income above a given threshold) administered by private health insurers	HF.2.2	Private insurance (other than social insurance)	HF.1.2.2	Compulsory private insurance schemes
Compulsory accident insurance for those having driving-licence	HF.2.2	Private insurance (other than social insurance)	HF.1.2.2	Compulsory private insurance schemes

68. The next step should be to identify the data sources (and any related data problems) to link the relevant financing scheme (HF) with the financing agent (FA). It can be useful to simply indicate the existence of data problems at this stage and then describe them separately, as well as list possible actions to tackle the problem, such as identifying an appropriate contact, identifying a distribution key, etc. In the case of multiple agents covering the functions of collecting, pooling and purchasing, the separate listing of these can help to identify multiple data sources from which data can be triangulated.

Task 3: Identification of the basic flows in health care financing

69. This entails a qualitative description of the main components of (i) revenue-raising by the financing schemes and (ii) allocation of resources by the financing schemes (according to functions or providers).

Identification of the revenues of financing schemes (FS)

70. The main tasks are to identify the types of revenues collected by each financing scheme and the data sources concerned.

71. Working through each financing scheme, the various types of transactions through which the given scheme obtains its revenues should be listed. The types of revenue transactions should be classified according to the SHA 2011 FS classification (Annex 2: Table A2.3).

72. In one-to-one cases where there is a single revenue source (e.g. where a government health programme is financed solely by government internal domestic transfers) then it is a simple case of adding the type of revenue directly to the information on financing schemes and financing agents. In more complex situations with multiple revenue sources and financing agents (or agents administering multiple schemes), Table 2.6 can provide a way of indicating the relevant FS-FA-HF relationships (by marking the relevant cells by "x"). At this stage it only identifies qualitative information regarding the existence (or non-existence) of a given type of revenue. The table also helps identify data needs and possible data-gaps. An additional line for each combination of financing scheme, financing agent and type of revenue can then be added to the database.

Table 2.6 Identifying types of revenues by financing scheme and financing agent

	FS Code		FS.1.1	FS.1.2	FS.1.3.	FS.1. 4	FS.2	FS.3.1	FS.3.2	FS.3.3	FS.3.4	FS.4.1.	FS.4.2.	FS.4.3.	FS.5.1	FS.5.2	FS.5.3	FS.6.1	FS.6.2	FS.6.3	FS.7
National description of scheme	**HF Code**	**FA Code**	Internal transfers and Grants	Transfers on behalf of specific groups	Subsidies	Other transfers from government domestic revenues	Transfers by government from foreign origin	Employee social insurance contribution	Employer social insurance contribution	Self-employed social insurance contribution	Other social insurance contribution	Compulsory prepayment from households	Compulsory prepayment from employers	Other Compulsory prepayment	Voluntary prepayment from households	Voluntary prepayment from employers	Other Voluntary prepayment	Other revenues from households n.e.c.	Other revenues from corporations	Other revenues from NPISHs n.e.c.	Direct Foreign transfers
Health system administration and governance	HF.1.1.1	FA.1.1.1	x																		
Central govt. financing of public health activities	*HF.1.1.1.1*	FA.1.1.1	x				x														x
Central govt. financing of National Emergency Service	*HF.1.1.1.2*	FA.1.1.1	x																		x
Health care scheme for govt. employees	*HF.1.1.1.3*	FA.1.1.2	x																		x
Health care scheme for army personnel	*HF.1.1.1.4*	FA.1.1.2	x																		x
Contribution to operating costs of state-owned health care providers	*HF.1.1.2.1*	FA.1.2	x		x																x
Statutory social health insurance (SHI)	HF.1.2.1	FA.1.3.1		x	x			x	x	x	x										
Statutory social health insurance (SHI)	HF.1.2.1	FA.2.2		x	x			x	x	x	x										
Statutory social health insurance (SHI)	HF.1.2.1	FA.2.2		x	x			x	x	x	x										
Statutory social health insurance (SHI)	HF.1.2.1	FA.2.2		x	x			x	x	x	x										
Statutory social health insurance (SHI)	HF.1.2.1	FA.1.3.2		x	x			x	x	x	x										
Compulsory private health insurance policies	*HF.1.2.2.1*	FA.2.1										x	x	x							
Statutory long-term care insurance scheme	*HF.1.2.2.2*	FA.1.3.2		x	x			x	x	x	x										
Statutory long-term care insurance scheme	*HF.1.2.2.2*	FA.2.1			x			x	x	x	x										
Payments by households	HF.2.1.2	FA.5																x			
Voluntary health insurance policies	HF.2.2	FA.2.1			x										x	x	x				
NGO health programme for drug addicts	HF.2.3	FA.4				x												x	x	X	x
Employers' occupational health schemes	HF.3	FA.3																	x		
Foreign aid	HF.4	FA.6																			x

73. Regarding data sources, it is preferable to obtain the majority of the necessary data from the financing agent that manages the purchasing function of the financing scheme. However, it may be that the institutional unit collecting revenues can differ from the financing agent paying providers. The previous step should clarify this and can help the health accountant to identify the revenue flows and possible data sources. Note, however that the revenues of the financing scheme should be accounted under the financing agent managing the purchasing function. Note that the administrative costs of the unit collecting the revenues for the scheme *may* have to be accounted for in the overall expenditure of the financing scheme.[14]

Possible data sources

74. Possible data sources for revenues of the financing schemes depend on whether the same financing agent acts as both revenue-collecting agent and purchasing agent for a given health financing scheme:

- If the same institutional unit collects revenues and pays for health care, its records and accounts can be used to obtain data on revenues and expenditures.
- If there is a separate revenue-collecting agent, the ideal case is to collect data both from the collecting agent and the purchasing agent and then to triangulate them. However, it may be that data are only available from the collecting agent. For example, a National Tax Authority may collect social insurance contributions from employers and employees and creates a National Health Insurance Fund. The NHIF is distributed among various social health insurance organisations based on a need-adjusted capitation. The individual social health insurance organisations may not have information about the share of the sub-categories of social insurance contributions (FS.3.1 to FS.3.4) in their revenues.
- There are also mixed forms of revenue collection. For example, employers' contribution may be collected in a centralised way, and individuals may pay directly to the insurance organisation to which they sign up. Therefore, in the case of complex schemes, an analysis of the FS-HF-FA relationship may be needed. (See Table 2.7).

Table 2.7 Compilation of data on revenues under different types of HF–FA relationship

Types of HF–FA relationship	Compilation tasks
One-to-one correspondence between FA(a) and HF(x)	HF(x) related revenue data collected from FA(a) can be directly entered into the HF(x) row of the HFxFS table. HF(x) related revenue should be separated from all revenues of FA(a).
FA(a) manages two different financing schemes: HF(x) and HF(y)	Data on revenues should be separated by the two financing schemes (See Table 2.8). The allocation of administrative costs of FA(a) between the two financing schemes may require specific estimation.
FA(a) manages HF(x), as well as another social welfare scheme (e.g., in-cash benefits, such as sick leave and family allowance, etc.)	Data on revenues of HF(x) should be separated from the revenues of other activities of FA(a). The administrative costs of FA(a) related to HF(x) should be estimated separately.

[14] See Chapter 4 for a more detailed discussion on the boundaries and inclusion of administrative costs.

Table 2.8 Separating data on revenues of HF.1.2.2 and HF.2.1 managed by the same financing agent (FA.2)

		Insurance corporations					
		FA.2					
		HF.1.2.2 Compulsory private insurance schemes		HF.2.1 Voluntary Health Insurance schemes		HF All schemes	
		Revenue	Note	Revenue	Note	Revenue	Note
FS.1	**Transfers from government domestic revenues**						
FS.1.1	Internal transfers and Grants						
FS.1.2	Transfers by government on behalf of specific groups						
FS.1.3.	Subsidies						
FS.1. 4	Other transfers from government domestic revenues						
FS.2	**Transfers distributed by government from foreign origin**						
FS.3	**Social insurance contributions**						
FS.3.1	Employee social insurance contribution						
FS.3.2	Employer social insurance contribution						
FS.3.3	Social insurance contribution from self-employed						
FS.3.4	Other social insurance contribution						
FS.4	**Compulsory prepayment (other than FS.3)**						
FS.4.1	Compulsory prepayment from individuals						
FS.4.2	Compulsory prepayment from employers						
FS.4.3	Other compulsory prepaid revenues						
FS.5	**Voluntary prepayment**						
FS.5.1	Voluntary prepayment from individuals						
FS.5.2	Voluntary prepayment from employers						
FS.5.3	Other voluntary prepaid revenues						
FS.6.	**Other domestic revenues n.e.c.**						
FS.6.1	Other revenues from households n.e.c.						
FS.6.2	Other revenues from corporations n.e.c.						
FS.6.3	Other revenues from NPISH n.e.c.						
FS.7	**Direct foreign transfers**						

75. Additional metadata can then be included to indicate actual data sources with codes for the revenues of each scheme. This can also be used to highlight any data problems.

76. An important point to note is that a financing scheme's revenues over a given period will usually not match the actual expenditure on health care goods and services by the given scheme over the same period. Therefore the financing scheme (HF) can be in deficit or surplus with regards to revenues (FS) in the accounting period. Since the starting point of the health accounts is the final consumption of health care goods and services, it is important to 'fix' the total expenditure of the financing scheme prior to estimating the total revenues. The issue of surpluses and deficits is also dealt with in Chapter 3.

Separating data on the revenues of HF.1.2.1 and HF.2.1, operated by the same financing agent (FA.2)

77. In Table 2.8, the main financing scheme is compulsory private insurance scheme, operated by private insurance companies that also offer complementary voluntary health insurance. Previously (under SHA 1.0), the revenues would have been accounted in the HFxFS table in the cells: FS.2.1 Corporations x HF.2.2 Private insurance enterprises and FS.2.2 Households x HF.2.2 Private insurance enterprises. However, under SHA 2011, revenues of HF.2.2 should now be disaggregated according to the two different schemes.

Database structure of schemes, revenues and agents

78. An example of the final structure of the possible linked information and the relevant column is shown in Table 2.9. Eventually, actual revenues can be added from the identified data sources and reconciled with the health spending estimates.

Table 2.9 Possible database structure for the transactions HF-FA-FS

2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Nat. desc.	**HF code**	**HF sub-code**	**HF desc.**	**Collecting agent**	**Purchasing agent**	**FA code**	**FA desc.**	**HF.RI code**	**FA data source**	**FS code**	**FS desc.**	**FS.RI code**	**FS data source**	**NCU**
Central govt. financing of public health activities	1.1.1		Central governmental schemes	Ministry of Finance	Ministry of Health	1.1.1	Ministry of Health	1.1	MoH	1.1	Internal transfer and Grants	1.1	MoH	
Central govt. financing of public health activities	1.1.1		Central governmental schemes	Ministry of Finance	Ministry of Health	1.1.1	Ministry of Health	.1.1	MoH	2	Transfer by govt. from foreign origin	1.5	MoH	

Calculating health expenditure by financing agents managing the financing schemes (HF.RI)

79. The example above also includes the coding of the financing agents managing the schemes as a reporting item to the HF classification (HF.RI), as well as the institution providing the revenues as a reporting item to the FS classification (FS.RI).

80. Under the memorandum items, "Financing agents managing the financing schemes", the sum of health spending administered by the given type of financing agents across all financing schemes can be reported. This is summarised as follows:

HF.RI.1.1	Government	ΣFA.1
HF.RI.1.2	Corporations	ΣFA.2 + ΣFA.3
HF.RI.1.3	Households	ΣFA.5
HF.RI.1.4	NPISHs	ΣFA.4
HF.RI.1.5	Rest of the World	ΣFA.6

Identification of the allocation of resources by financing schemes

81. From the basis of the structure of financing between HF and FA completed at the end of Task 2, a similar process can be used to help identify the relevant providers/functions for each financing scheme, and the respective financing agents for which the given financing scheme (through the given financing agent) allocates its financial resources. One approach is to compile a table similar to Table 2.5, for health care providers (HP) and health care functions (HC) identifying the relevant items of the allocation of resources for a given financing scheme (e.g., by an "x).

82. Similar issues concerning the HF-FA relationship arise when compiling data on expenditures by function and provider, but from the point of view of FA as a purchasing agent. In summary, Table 2.10 outlines the compilation tasks according to the different types of HF-FA relationship.

Table 2.10 Compilation tasks under different types of HF–FA relationship (Tables HC x HF and HP x HF)

Type of HF–FA relationship	Compilation tasks
One-to-one correspondence between HF(x) and FA(a)	Data collected from FA(a) can be directly entered into HFxFAxHC or HCxHF table
FA(a) manages two different financing schemes: HF(x) and HF(y)	Data on expenditure should be collected (or estimated) separately for each financing scheme managed by FA(a). The allocation of administrative costs of FA(a) according to the financing schemes may require specific estimation.
FA(a) manages HF(x), as well as another social welfare scheme (e.g., in-cash benefits, such as sick leave or family allowance, etc.)	It is expected that most schemes and agents have records of expenditures. When missing, estimations may be required. Data on HF(x) should be separated from the other activities of FA(a) The administrative costs of FA(a) related to HF(x) will need to be estimated.

83. In some cases there can be an information gap between the revenue-raising function of a scheme and the end-purchasing function that hinders the linking of expenditures to specific schemes. As in Table 2.7, a single financing agent can manage different revenue streams (e.g. compulsory and voluntary contributions) which are pooled together and make it difficult to fully determine the origin of the funds (and thus scheme) when health services are purchased.[15] The use of funds may also be at the discretion of the financing action to finance other services for other beneficiary groups. In this case there may have to be specific estimations made to determine the allocation to the appropriate scheme.

84. In order to start compiling data on expenditures, the next step can be to prepare a separate working sheet for each of these financing agents showing the breakdown of data (HP and/or HC) by each of the financing schemes managed (Similar to Table 2.8 but for providers and/or functions rather than revenues). These tables can be used directly to compile data from the agents or to make estimations.

[15] For example, there has historically been only partial reporting for the *Seguro Popular* in Mexico, or ISAPRES in Chile, where it a challenge to separate the expenditure according to compulsory and voluntary contributions.

CHAPTER 3 MAPPING FROM SHA 1.0 TO SHA 2011 CLASSIFICATIONS OF HEALTH FINANCING

This chapter provides: (i) an interpretation of the transition from SHA 1.0 to SHA 2011 (ii) practical guidance concerning the mapping of the SHA 1.0/PG categories to the categories of financing schemes and revenues and (iii) discusses the specific issue of surpluses and deficits.

85. It is vital to ensure an adequate, smooth transition from SHA 1.0 to SHA 2011, in order to preserve the results from previous implementations of SHA 1.0. This requires mapping between the categories of classifications of health financing under SHA 1.0 and SHA 2011.

Transition from the Classification of Health Care Financing under SHA 1.0 to the Classification of Health Financing Schemes under SHA 2011

Interpreting the transition

86. Adequate mapping of the categories (and data) of the Classification of Health Care Financing under SHA 1.0 to the categories of the Classification of Health Financing Schemes under SHA 2011 requires health accountants to understand the conceptual differences between the two classifications.

87. The main conceptual changes are that SHA 2011:

- makes a clear distinction between financing schemes and the financing agents (institutions) administering the financing schemes, defining HF as financial schemes;
- treats the issue of surplus/deficit of financing schemes differently from SHA 1.0;
- provides a more coherent interpretation of "public" and "private" in health financing.[16]

88. SHA 1.0 did not make a clear distinction between financing schemes and the institutional units managing financing schemes. The definitions for most of the categories of ICHA-HF were taken from SNA93 (definitions for the institutional sectors) and no longer provide an adequate interpretation for the health care sector. This institutional approach is not able to reflect the increasingly complex arrangements of health financing. Similar purposes (e.g., to ensure access to care to the whole or majority of population) with similar benefit packages can be achieved with different institutional arrangements (i.e., with a different public-private mix in the institutional arrangements in financing). With a classification of health financing based on institutional settings, this causes increasing problems for international comparisons. For example, a key problem is that SHA 1.0 is not able to distinguish between the type of insurance scheme and the type of insurer organisation. The reporting of compulsory private insurance under "General government" or under "Private sector" is not adequate and distorts comparison across countries with different institutional settings.

89. SHA 2011 replaces the institutional approach by the concept of financing schemes (using a "functional approach"), drawing on the European System of Integrated Social Protection Statistics (ESSPROS). The criteria for defining the categories of financing schemes are the mode of participation in the scheme, the basis for entitlement to health care and the rules of raising and pooling revenues of the given scheme.

[16] The changes in interpretation of "public" and "private" in health financing are discussed in Chapter 5.

Mapping the transition

90. Table 3.1 shows some typical cases that may arise in mapping HF (SHA 1.0) to HF (SHA 2011). The first two columns show HF under SHA 1.0. The SHA 2011 part of the table illustrates two possible cases:[17]

- mapping to the "default" scheme. For example, HF.1.1.1 is mapped by "default" to HF.1.1.1 Central governmental schemes
- mapping to a different (non-default) scheme. For example, (part of) HF.1.2.1 may be mapped to HF.1.2.2. Compulsory private insurance. See Table 3.2.

91. The basic information needed for the mapping is provided by the definitions of HF categories; Main criteria of health financing schemes; and the criteria tree for health financing (Annex 2).

Table 3.1 Mapping HF (SHA 1.0) to Classification of Financing Schemes under SHA 2011

SHA 1.0		**SHA 2011**			
		"Default" financing scheme		**Other "possible" financing scheme**	
HF.1.1.1	Central government	HF.1.1.1	Central governmental schemes	HF.2.2 (1)	NPISHs financing schemes
HF.1.1.2	State/provincial government	HF.1.1.2	State/regional/local governmental schemes		
HF.1.1.3	Local/municipal government				
HF.1.2	Social security funds	HF.1.2.1	Social health insurance	HF.1.2.2	Compulsory private insurance
				HF.2.1	Voluntary health insurance schemes
HF.2.1	Private social insurance	HF.2.1	Voluntary health insurance schemes	HF.1.2.1	Social health insurance scheme
HF.2.2	Private insurance enterprises (other than social insurance)			HF.1.2.2	Compulsory private insurance
HF.2.4	NPISHs (other than social insurance)	HF.2.2	NPISHs financing schemes	HF.1.1.1	Central governmental schemes
HF.2.5	Corporations (other than health insurance)	HF.2.3	Enterprises financing schemes		
HF.2.3	Private household out-of-pocket expenditure	HF.3	Household out-of-pocket payment		
HF.3	Rest of the world	HF.4	Rest of the world financing schemes	HF.2.2	NPISHs financing schemes

(1) Rather than being accounted as a central government financing scheme, it is possible that is should be classified as a transfer to another financing scheme (e.g. operated by a NPISH) and thus treated as a revenue source.

Practical guidance

92. The conceptual change has to be taken into consideration in the process of mapping between SHA 1.0 and SHA 2011. The following approach is similar to the general approach in Chapter 2 but starts from the point of view of each existing SHA 1.0 financing category. Since countries may

[17] It may be the case that spending by a financing scheme should in fact be accounted as revenue for other financing schemes. For example, rather than being accounted as central government spending, in fact, this should be accounted as FS.1.4 Other transfers from government. See Chapter 4.

aggregate several country-specific financing arrangements under a single HF category, an appropriate mapping requires information at this country-specific level.

93. Table 3.2 provides one approach for treating complex financing arrangements, presenting a hypothetical example mapping HF.2.2 (SHA 1.0) to HF categories under SHA 2011.

- Step 1: All country-specific financing arrangements included under HF.2.2 (SHA 1.0) should be listed in Columns (1) of Table 3.2.
- Step 2: The mode of participation, benefit entitlement and basic method for fund-raising of the country-specific financing arrangements should be clarified. (Columns 2-4.)
- Step 3: Financing schemes can be identified and categorised under HF Classification of SHA 2011 (Column 6-7) based on the information gained in Step 2, and (if necessary) by the definitions of HF categories and Criteria tree for health financing (See Annex 2).

94. Table 3.2 shows that HF.2.2 Private insurance enterprise in the SHA 1.0-based health accounts is in fact the sum of three insurance programmes; all managed by private insurance enterprises. In previous NHAs compiled under SHA 1.0, all spending by private insurance companies was reported under HF.2.2 (SHA 1.0).

95. Based on an analysis of the mode of participation and benefit entitlement, it can be seen that these have the characteristics of three different financing schemes. Hence, these should be reported under the appropriate HF categories under SHA 2011.

96. The data on spending previously reported under HF.2.2 (SHA 1.0) can be allocated accordingly (Column 5). Calculating the spending by the different schemes requires the disaggregation of the data reported by insurance companies (now considered as a financing agent under SHA 2011). To obtain these data from the insurance companies may require specific data-collection or estimations. Spending on HF.1.2.1 previously reported under HF.2.2 (SHA 1.0) should be aggregated with any other data on HF.1.2.1, in order to obtain the final value of HF.1.2.1 under SHA 2011.

Table 3.2 Mapping HF.2.2 (SHA 1.0) to categories of the Classification of Financing Schemes

Programmes managed by HF.2.2 Private insurance enterprises (SHA 1.0)	**Mode of participation**	**Benefit entitlement**	**Basic method for fund-raising**	**NCU**	**Financing scheme (SHA 2011)**	
(1)	(2)	(3)	(4)	(5)	**(6)**	**(7)**
Compulsory health insurance for persons with income above a certain level	Compulsory for a given group of population	Based on individual contracts			HF.1.2.2	Compulsory private insurance scheme
Compulsory insurance	Compulsory for the whole population	Based on the relevant law			HF.1.2.1	Social health insurance scheme
Voluntary health insurance	Voluntary	Based on individual contracts			HF.2.1	Voluntary health insurance scheme

Mapping NPISHs (SHA 1.0) to financing schemes

97. In many cases, NPISHs generate their revenues mostly from the private sector and take decisions without the involvement of the government. Control is mostly in NPISHs, and they decide where to allocate funds. In this case, data can only be obtained from surveys on the NPISHs.

98. When there is a substantial involvement by the government, it may be difficult to decide whether the spending by a NPISH (HF.2.4 under SHA 1.0) which receives money from the government should be accounted under SHA 2011 as:

- spending by HF.2.2 NPISHs financing schemes (receiving revenues from the government); or
- spending by HF.1.1.1 Central governmental schemes, administered by NPISH (as a financing agent)

99. The key issue to distinguish between these two arrangements is the nature of the programme.

- The programme is developed and the related budget is set by the Ministry of Health; the key decisions are also done by the MoH. The MoH contracts the NPISH for the implementation according to the plan, budget and conditions set by the MoH. In this case the scheme is accounted as HF.1.1.1 administered by FA.4 (NPISH).
- NPISH established a programme (for example, a health centre for the homeless), applies for government money and also collects donations from enterprises and households. This case is accounted as HF.2.2 NPISHs financing scheme (administered by NPISH), and the relevant government spending as a revenue (FS.1.4) of the scheme, which is a component of the total revenues of HF.2.2.

Transition from the Classification of Financing Sources (PG) to the Classification of Revenues of health financing schemes under SHA 2011

Interpreting the transition

100. Adequate mapping of the categories (and data) of the Classification of Financing Sources (applied under PG) to the categories of the Classification of Revenues of Financing Schemes under SHA 2011 requires health accountants to understand the conceptual changes between the two classifications. The main conceptual changes are as follows:

- a shift from the concept of "financing sources" as institutional units to revenues of the financing schemes
- the treatment of surplus/deficit of the financing schemes
- the interpretation of "public" and "private" finance

101. SHA 2011 provides the following definition: Revenue is an increase in the funds of a health financing scheme, through specific contribution mechanisms. The categories of the classification are the particular types of transaction through which the financing schemes obtain their revenues.

102. The difference in the concepts has implications on the actual values of data. Under the JHAQ (based on SHA1.0/PG), the FS data showed the sources of the expenditure used for final consumption in the given accounting period. Consequently the aggregate value of FS was necessarily equal with the aggregate value of HF. Under SHA 2011, data on revenues of a financing scheme include all revenues raised by the financing schemes in a given accounting period (usually in a given year). Consequently, revenues may not equal with spending.

103. Operation of a financing scheme involves several types of transactions from the revenues received, such as:

- Payments for health services and goods purchased (benefits received by the people covered by the given scheme)
- Payments for the costs of provision of health services and goods (if purchasing and provision is not separated)

- Payments related to transactions costs of revenue-raising, pooling, management and purchasing (i.e. the administrative costs of the scheme)
- Other spending executed from the revenues of the scheme

Table 3.3 Comparison of the concept of Revenues of Financing Schemes with Financing Sources under the Producer Guide (2003)

	Revenues of Financing Schemes under SHA 2011	**Financing Sources under PG (2003)**
Definition of the units of the classification	*Revenues of financing schemes* (transactions, *e.g.* social insurance contributions, etc.).	*Institutional units of the economy* whose resources are mobilised and managed by financing schemes (government, corporations, etc.)
Key information provided by the classification	"How" revenues are mobilised by financing schemes (type of transactions)	"From whom" revenues are collected by financing schemes
Value of the categories accounted	All revenues raised through the given type of transaction/mechanism	The sources of the expenditure used for final consumption in the given accounting period
Criteria for grouping the categories	Compulsory versus voluntary transaction; domestic versus foreign origin	Whether the institutional unit providing the resources is regarded as a public or private institutional unit

104. Transactions related to the operational improvement of the scheme (e.g., investment in the infrastructure of the financing agents) should be separated and not taken into account since, by definition, the revenues need to be limited to current spending. For example, a private insurance company may own and operate its own out-patient facilities. A part of the insurance premiums collected as revenues of the voluntary health insurance scheme may be used for investments related to those facilities.

Practical guidance

105. Mapping the FS (PG/JHAQ) categories to categories of the Classification of Revenues of Health Financing Schemes under SHA 2011 means clarifying the type of transactions (type of mechanisms) between the providers of revenues and the financing scheme (more precisely, the financing agent operating the financing scheme concerned). A table showing the relationships between the providers of revenues and the types of revenues is suggested (Table 3.4).

106. Reporting the transactions means in several cases separating values reported under the previous institutional definition of financing source. For example, payment by government to social security funds may be separated into the following revenues streams: (i) payment of social health insurance contribution by the government on behalf of specific population groups, (ii) payment of voluntary insurance fee by the government as a fringe-benefit for government employees (the VHI is operated by the same social insurance agencies as the SHI scheme), (iii) transfers to cover the deficit of the operation of social insurance scheme. The relevant information to determine the separation may be available in detailed budgets of the Government.

107. In completing Table 3.4, begin by preparing the upper part of the table. The first step is to determine the various types of transaction payments (the revenues of the recipient) for each institutional unit (providing revenues). To determine this, ask the question, "Through which mechanisms do the institutional units of the economy provide revenues to financing schemes?" In some cases, the mapping is obvious, based on information provided by the "old" HFxFS table.

However, in some cases, in particular in the case of government and RoW, the mapping may require a more detailed examination (e.g., filling some of the tables presented in Chapter 4 and 6).

108. The second step is to prepare the bottom part of Table 3.4 in order to assign the types of revenues to the financing schemes. Again, in the case of government and RoW, it may require a more detailed examination.

109. Table 3.4 shows, for example, the separation previously accounted under *FS.1.1* Territorial government:[18]

- GOV5 indicates an amount for which the source is general budget support from foreign origin. Therefore, it is accounted as FS.2 under SHA 2011.
- As a result of disaggregation, it can be seen that the amount of Transfers from government domestic revenue (FS.1 under SHA 2011) is smaller than Territorial government (FS.1.1 under PG).

Health accountants should also consider whether previous FS data produced should be revised or if a methodological break in the data series should be indicated.

The treatment of surplus funds or deficits under SHA 2011

110. The allocation by provider and function shows the total spending by health financing schemes in a given accounting period, while the revenues of the health financing schemes[19] in the given same period may be greater or smaller than the expenditure on health services and goods by the given scheme. Therefore, the total expenditure when extracting information on HCxHF and HPxHF does not necessarily equal the total revenues in HFxFS table. This can be displayed as an additional column with the total current expenditure by financing schemes and a column showing the operating balance (revenues minus expenses of each health financing scheme) added to the table. (Table 15.5 in the SHA 2011 Manual).

111. In the case of some specific financing arrangements, the actual measurement of revenues may be difficult. For example, social insurance schemes in several countries finance not only health care goods and services but other social services as well. In such cases, only revenues used for the expenditure on health care goods and services should be taken into account. This is also relevant for schemes such as Long-term care insurance where services outside of the health care boundary may be financed. As revenues may not be fully separated between the different spending components of such social insurance schemes, the analysis of deficits and surpluses of such health insurance schemes – although possible – may be highly influenced by the assumption of how to calculate "health-related revenues".

[18] See Chapter 7 for a more detailed discussion of sector accounts.

[19] Revenues here refer to revenues used for the purposes of financing consumption expenditure and not, for example, investments.

Table 3.4 Mapping the FS (PG/JHAQ) categories to the categories of Classification of Revenues of Health Care Financing Schemes

Revenues of financing schemes (SHA 2011) Financing Sources (PG)	**FS.1** **Transfers from government domestic revenue**	FS.1.1 Internal transfers and grants	FS.1.2 Transfers by government on behalf of specific groups	FS.1.3 Subsidies	FS.1.4 Other transfers from government domestic revenue	**FS.2** **Transfers distributed by government from foreign origin**	**FS.3** **Social insurance contributions**	FS.3.1 Social insurance contributions from employees	FS.3.2 Social insurance contributions from employers	FS.3.3 Social insurance contributions from self-employed	FS.3.4 Other social insurance contributions	**FS.4** **Compulsory prepayment (other than FS.3)**	**FS.5** **Voluntary prepayment**	**FS.6** **Other domestic revenues n.e.c.**	**FS.7** **Direct foreign transfers**	**All FS** **All revenues of financing schemes**
General government units FS.1																
Territorial governments FS.1.1	**∑GOV-GOV5**	GOV1	GOV2	GOV3	GOV4	**GOV5**										**∑GOV**
All other public units FS.1.2							**PUB1**				PUB1			**PUB2**		**∑PUB**
Private sector FS.2																
Corporations and NPISHs FS.2.1/2.3							**CORP1+ CORP2+ CORP3**		CORP1	CORP2	CORP3		**CORP4**	**CORP5**		**∑CORP**
Households FS.2.2							**HH1+ HH2**	HH1		HH2			**HH3**	**HH4**		**∑HH**
Rest of the world FS.3															**ROW1**	**∑ROW**

CHAPTER 4 THE GOVERNMENT'S ROLE IN THE HEALTH CARE SYSTEM

This chapter provides guidance in accounting the different roles of Government from two perspectives: (i) the possible types of health-specific transactions from the state budget and (ii) the possible roles of government units from an institutional approach. An example is presented for the key issue of separating the transactions by governmental health financing schemes – i.e. purchasing of services from the providers (accounted as HF.1.1–HP transactions) from the transactions of providing revenues from government to other financing schemes (accounted as FS.1-HF transactions).

112. From a health policy approach, the government can be involved in the following functions of the health care system: [20]

- governance/regulation
- revenue-raising
- pooling of resources
- purchasing
- provision of services
- resource-generation (investment in human and physical capital and R&D)

113. From a health accounting approach, health accountants first need to make a distinction between the flows (transactions) and the institutions involved. The government (government units') budget for health is often the starting point to identify the following types of transactions:

- Transactions related to revenue-raising and pooling;
- Transactions related to health care functions;
- Transactions related to health-related functions (HC.R.1, HC.R.2);
- Transactions (by government health financing agents) related to non-health functions;
- Transactions related to resource-generation (investment in human and physical capital and R&D)
- Transactions (by the government) to other health financing schemes;
- Transactions made as an intermediary institution (e.g., between foreign NGOs and local NGOs);

114. From an institutional approach, government units can play the following roles:

- provider of revenues of financing schemes
- financing agent involved in collecting and pooling of revenues
- financing agent purchasing services
- intermediary organisation (i.e., solely conveying revenues between providers of revenues and the financing schemes concerned, both between levels of government and to other non-governmental organisations)

[20] In addition, government is also a consumer of some health services on behalf of households.

- institutions performing health system governance and financing administration
- owners of health care provider institutions[21]
- owners of institutions performing health care-related functions

115. Table 4.1 shows how these functions and institutional roles are accounted under SHA 2011.

Table 4.1 Accounting the government's involvement in the health care system

Main role of the government's involvement	Health accounting terms	SHA 2011 item describing the relevant transaction
Regulation	Administrative activities of Governmental schemes (HF)	HC.7xHF.1.1 HP.7.1xHF.1.1
Revenue-raising	Provider of revenues	FS.1xHF.1 FS.1xHF.2
Collecting and pooling	Institution collecting and pooling revenues	HF.1.**1xFA.1xHC**.7
Purchasing	Financing agent paying for services	HF.1.1xHC HF.1.1xHP
Provision of services	Owner of provider	No distinction made in HP

The role of government in revenue-raising

116. The role of government in revenue-raising requires particular consideration. In a macroeconomic sense, there are a number of ways that health care financing schemes (or the agent managing the given scheme) raise their revenues:

- Revenues are received directly from the primary owners of income[22]: households, corporations and the rest of the world (e.g., foreign government, international organisations, foreign private organisations or foreign households). The level of revenue is decided by regulation, contracts or decisions made by the primary owners of income;
- Revenues are received as the result of the allocation of government general and/or earmarked revenues. First, the government raises revenues for their overall activities from the primary owners of income, before allocating the revenues among the different public spending areas, including health financing schemes;
- Revenues can be received from a foreign or domestic NGO that is only involved in collecting financial resources from different foreign or domestic entities and then provides support to other NGOs.

117. In the case of non-earmarked revenues of the state budget, there is no direct link between the type of government revenue[23] (income tax, VAT, corporate taxes, grants, sales, etc.) and the area of spending (e.g., education, health, etc.). It is a budget decision that determines the revenues dedicated to health purposes. Therefore, FS.1 Transfers from government domestic revenues includes non-earmarked government domestic revenues allocated to health purposes; and FS.2 Transfers distributed by government from foreign origin includes (although not exclusively) non-earmarked foreign revenues subsequently allocated to health purposes.

[21] The central and local government can be the owner of a health care provider institution and outsource the operation of the provider institution to a private company.

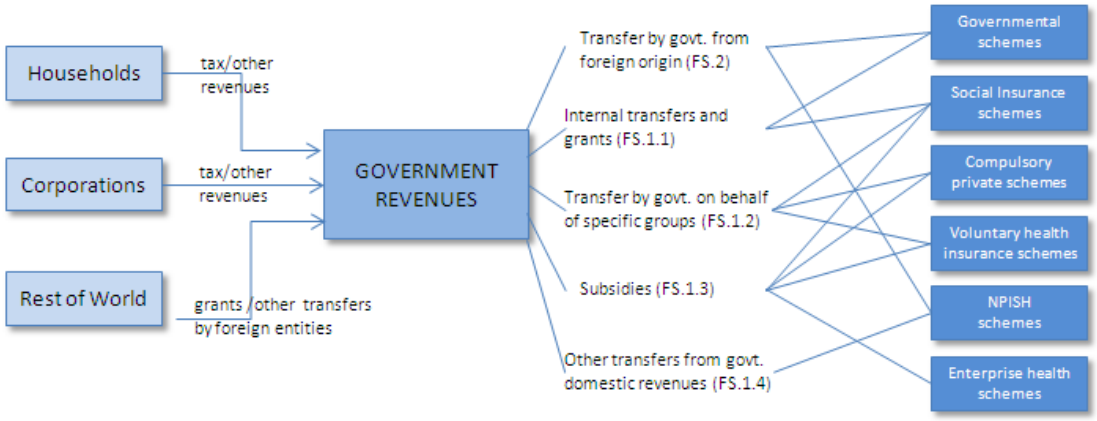
[22] Here, Government as a primary owner of certain income, *e.g.* from selling properties, is disregarded. However, in some countries, government, as primary owner of income, should also be taken account. For example, in many oil producing countries this is an important source of income for the government.

[23] It is beyond the scope of these Guidelines to examine the different types of general government revenues (*e.g.* the share of personal income tax, VAT, etc.).

118. The main primary owners of income are households, corporations and the rest of the world. However, due to its decision-making role concerning the allocation of its general revenues, it is important to also show government as an institutional unit that allocates revenues to health financing schemes (Figure 4.1).

119. In order to provide a transparent picture of the role of government, the sub-categories of FS.1 make a distinction between internal transfers (for example, allocations from the central government budget to the Ministry of Health and grants to local governments); a contribution by government on behalf of specific groups (for example, on behalf of children, the elderly, the inactive poor, etc.); subsidies (e.g. to employers buying health insurance for their employees); and other transfers from government domestic revenues (such as for NPISH, or payment by government buying health policies from private insurers for its personnel/civil servants). The sectoral account of Government is the appropriate tool to account the transactions illustrated by Figure 4.1. (See Chapter 7)

Figure 4.1 Example of the role of government in revenue-raising[24]



Specific accounting issues related to government

120. The following issues of government involvement require additional guidance. Their importance and relevance can vary across countries:

- Distributing revenues of foreign origin by the government
- Accounting earmarked tax used for health financing
- Administrative costs of health-specific activities of the government
- Tax incentives and financial advantages e.g. connected with the purchase or offering voluntary insurance (See Chapter 5)
- Cash or accrual accounting (See Chapter 5)

Accounting foreign aid received by the government

121. Donors, types and purposes of foreign aid can vary greatly across countries. Foreign aid can be managed through the central government budget, provided directly to financing schemes (financing

[24] Government may also receive income from its own resources, e.g. income from oil.

agents) other than governmental schemes, or provided directly to health care providers. This section discusses only the accounting issues of foreign aid received by government. [25]

122. Regarding foreign aid and the budget process; first, the difference between 'General Budget Support' and 'Sectoral Budget Support' should be clarified. In the former, the use is decided by the recipient government, while in the latter, the sector of use is agreed between the donor agency and the recipient government.

123. It is recommended to first prepare a qualitative description listing the various donor categories, type of aid and the purposes for which the aid is used. Table 4.2 deals with the accounting of foreign aid under SHA 2011:

- to decide which items to be included or not under the health accounting boundary;
- to decide the appropriate FS and HF categories for those amounts;
- to use the information to prepare a sectoral account for government (if needed).

124. Foreign general budget support is used at the discretion of the recipient government. In the absence of information to the contrary, it might be assumed that only governmental health financing schemes receive revenues from foreign general budget support. (As a consequence, it is supposed in this case that the sources of support from government to other financing schemes – e.g., to NGOs financing schemes – are either health-specific foreign aid or transfers from government domestic revenues.)

125. Accountants will need to impute the amount of general budget support allocated for health purposes. One possible way is to assume that the share of foreign general budget support allocated to health is the same as the overall share of health expenditure in the government budget (**FS.2 x HF.1.1).** The Government/Ministry of Health may also channel foreign aid to support health programmes of NPISHs (accounted under SHA 2011 as **FS.2xHF.2.2**[26]), and other types of schemes as well as providers.

126. Note that when the government reaches agreement with donors to forward aid to domestic non-profit organisations or providers, the government *only* performs the function of an intermediary organisation. Therefore, depending on the actual details, this should normally be accounted as **FS.7**.

127. Direct foreign aid to government may be used in the following ways:

- as direct revenue for government health financing schemes, programmes, health facilities (accounted under SHA 2011 as Direct Foreign transfers, a revenue of governmental financing schemes**: FS.7xHF.1.1**);
- for financing health-related activities of the government (outside the boundary of health expenditure but the transaction should be included and reported; and also included in the government sectoral account);
- for financing capital formation (outside the boundary of health expenditure but the transaction is included and reported in a capital account; and also included in government sectoral account).

[25] Chapter 6 provides a general description of the accounting of foreign aid and correspondence with DAC statistics, including a more detailed categorisation of foreign aid.

[26] HF.2.2 in the case whereby the NPISH exercises decision-making powers. See Mapping NPISHs (SHA 1.0) to financing schemes in Chapter 3.

Table 4.2 The accounting of foreign aid received or administered by the government

	Destination/purpose of foreign aid			
Type of foreign aid	Revenues of governmental health financing schemes (HF.1.1)	Revenues of government for health-related activities (e.g. HC.R.2)	Aid for capital formation (including R&D)	Transfers distributed by the government to financing schemes other than HF.1.1.
Non earmarked general foreign aid	FS.2 (assumptions required on share allocated to health)	Sectoral account of the government	Capital account/ Sectoral account of the government	FS.2*
Earmarked foreign aid	FS.2	Sectoral account of the government	Capital account/ Sectoral account of the government	FS.2
Direct foreign aid	FS.7	Sectoral account of the government	Capital account/ Sectoral account of the government	Not-applicable

* In the case of non-earmarked funds, it may be difficult to distinguish government transfers received from foreign origin from those of government domestic revenues.

Box 4.1 Example of accounting of foreign aid

A simplified numerical example is provided for the illustration of accounting the different types of foreign aid.

A country has the following revenues of foreign origin (Million NCU)

Total revenues of the government:

Tax and other domestic government revenues	10000
Bilateral general budget support	500
Direct health-specific multilateral aid	50

Foreign aid to organizations other than government

Direct foreign aid in goods by a foreign NGO to providers	20

The government allocates 5% of the state budget for health purposes, and the whole amount is managed by the Ministry of Health. Direct foreign aid in goods by a foreign NGO is distributed directly by the foreign NGO to providers.

Accountants should decide how to estimate the share of the bilateral general grant. In the absence of any additional information, one approach is to assume the same share of the general grant as revenues of the health system as the share of health spending in the state budget as a whole. Therefore, it is assumed that 5% of the bilateral general grant is allocated for health purposes.

Revenue	Total revenues	Revenues to health	FS code	FS label
Tax and other domestic government revenues	10000	500	FS.1.1	Internal transfers and grants
Bilateral general grant to the government	500	25	FS.2	Transfers distributed by government from foreign origin
Direct multilateral aid to the governmental scheme	50	50	FS.7.1.2	Direct multilateral financial transfers
Direct foreign aid goods by a foreign NGO to providers	20	20	FS.7.2.1.3	Other direct foreign aid in goods

128. Foreign aid may be reported as FS.2 or FS.7 depending on country-specific accounting rules. What may be more important, however, is the reporting item FS.RI.2 which sums up the transfers distributed by government from foreign origin (FS.2) together with direct foreign transfers (FS.7) to give a full measure of total foreign revenues.

Accounting tax earmarked for health

129. In some countries, earmarked taxes used for health financing can play a considerable role. In such a case where there is significant policy relevance, it might be appropriate to create subcategories within FS.1: Transfers from government domestic revenues. For example, for internal transfers to governmental financing schemes, the following subcategories FS.1.1.1 and FS.1.1.2 could be considered:

FS.1.1	Internal transfers and grants
FS 1.1.1	Internal transfers and grants from general revenues
FS.1.1.2	Internal transfers and grants from earmarked tax
Etc	

Accounting the administrative costs of financing schemes

130. The administrative costs of a financing scheme are the costs related to collecting and pooling revenues of the given scheme as well as the costs related to purchasing services and goods under the given scheme. These activities may involve several agencies. In theory, administrative costs of a financing scheme should include all administrative costs of all these functions regardless of how many intermediaries are involved. [27]

131. As stated, revenues used by a health financing scheme for purchasing health care goods and services may have passed through multiple intermediaries before reaching the financing agent. Each will have some administration costs attached. In addition to the practical measurement issues, it is important to set a boundary on which institutions are included in the health system. As a general rule of thumb, the boundary could be set at the point where the funds become "earmarked" for health purposes. In this case, a proportion of the administration costs involved in general tax collection would be inappropriate. When budgetary decisions are made and funds are then transferred to another government agency for further distribution, then from this point, the administration costs should be taken into account.

132. For example, the National Tax Office in a country might be responsible for collecting the health insurance contributions from employers and employees for the social health insurance scheme before transferring this revenue to the Social Health Insurance Agency. Ideally, all costs related to collecting and pooling and purchasing under the given scheme should be accounted as spending by the social health insurance scheme (that is, including the relevant costs occurring at the National Tax Office). In this case it could be argued that the tax office acts as an outsourced collection service for the social health insurance since, if the tax office did not collect the premiums the social health insurance would do it and incur the necessary costs.

133. In addition to the above, accounting administrative costs faces a number of potential issues:

- Social health insurance may provide other benefits, such as sick leave or disability allowances, in addition to health care benefits (services and medical goods);
- Social health insurance may be a secondary activity of an institution (e.g., pension funds);
- An institution (e.g., private health insurance company) may manage two different schemes: compulsory insurance and voluntary insurance;
- health-related insurance may be a secondary product of private insurance companies;
- An NGO may have activities in several areas, including health;
- An enterprise's health financing schemes may not record its administrative costs.

[27] Note that administrative costs occurring at the providers are part of the value of the given services.

134. It may be that institutions concerned have separate records on administrative costs of health financing schemes. For example, in a private health insurance company different units may be responsible for managing the compulsory insurance and voluntary insurance and may have separate records on the related administrative costs. However, in most cases, data are not available on the administrative costs of individual health financing schemes and therefore health accountants have to make assumptions.

135. For example, estimations on administrative costs[28] of a given financing scheme (HF(x)) can be based on:

- the ratio of employment costs or number of staff involved in managing HF(x) to the total manpower costs or number of staff of the institutional unit which manages not only HF(x), but other financing schemes too; and/or
- the ratio of spending on the services and goods provided by HF(x) to the total spending on benefits by the institutional units concerned.

136. The choice between the two approaches depends on the nature of the problem and the availability of data. It is important to make the applied methodology transparent for the cases when administrative costs are not included in NHAs. In general, if most of the working time of the concerned persons is mainly related to the estimated administrative costs of the health financing scheme, it is better to use the approach based on the number/employment costs of the staff concerned. Two possible options exist for this case:

- The administrative costs of the organisation are separated into (i) manpower costs and (ii) other costs. If possible, the actual manpower costs of managing the health financing schemes are recorded. The ratio of the number of the persons managing the health financing schemes to the number of total employees of the organisation is applied in calculating the other costs of the health financing schemes.
- If manpower costs of persons managing the health financing schemes are not available, the ratio of the number of the person managing the health financing schemes to the number of the total employees of the organisation is applied to the total administrative costs of the organisation concerned.

137. In such cases it may be reasonable to make estimations only every three or four years and apply these same ratios (keys) to the total administrative costs of the institutions concerned in the intervening years.

Tracking the administrative costs of foreign assistance

138. The particular case of accounting the administrative costs of often complex institutional arrangements related to foreign assistance is of great importance. A donor (i.e. the original provider of resources) may give funds to an international NGO, who then passes money to a local or country NGOs to implement certain health functions. At each stage NGOs deduct funds for administration.

In such cases the administration costs should only be taken into account at the point where revenues for health purposes are received within the domestic economy, e.g. by the local NGO, either to be passed on to another agent, used to pay providers or to provide the services themselves.

Accounting administrative costs of health-specific activities of government

139. Administrative costs of a financing scheme and the administrative costs of the institutional unit managing the scheme should be treated separately (since, for example, the institutional unit may manage more than one financing scheme).

[28] T-accounts can be a useful instrument in this process

140. Administrative costs of a financing scheme are the costs related to collecting and pooling revenues of the given scheme, and the costs related to purchasing services and goods under the given scheme. These activities may involve several agencies. Administrative costs of all the institutional units involved should be taken into account (summed up).

141. It is important not to account all the administrative costs of government agencies involved in health financing e.g. the Ministry of Health, as administrative costs of HF.1.1. Only those administrative costs related to the operation of HF.1.1 schemes should be accounted as HC.7.2xHF.1.1.

142. Administrative costs of the Ministry of Health and other government agencies can be related to the following activities and roles of the government:

- providing revenues to other financing schemes. The accounting category for the related administrative costs for government supported financing schemes is HC.7.2. For example, HC.7.2xHF.2.2.
- financing agent involved in collecting and pooling of revenues (HC.7.2 x HF.1.1)
- financing agent paying for services (HC.7.2 x HF.1.1)
- intermediary organisation (only involved in conveying the revenues between providers of revenues and financing schemes concerned) (HC.7.2 x HF.2 or HF.4)
- performing governance, and health system and financing administration (HC.7.1 xHF.1.1)
- owners of health care provider institutions. The related administrative costs are an item of production of services and are not accounted as HC.7.
- owners of institutions performing health care-related functions. The related administrative costs are an item of production of services and are not accounted as HC.7.
- costs of non-health related activities of Ministry of Health and other government units acting as FA. These costs usually should be excluded. (For example, in a country a joint ministry – e.g., Ministry of Health and Social Affairs – may administer health and social issues. In this case, the costs of administration of social affairs should be excluded from HC.7xHF.1.1.1).

Box 4.2 An example of accounting government health-specific activities

The health care budget of the central government includes the following items:

Ministry of Health

Payments for operating the National Ambulance Service

Payments to hospitals owned by the central government

Payments to health centres operated by private organisations (purchase of services).

Payments for public health programs financed through an application (e.g. activities to enhance the health awareness of the youth). Applicants must define the concrete program and cover certain part of the costs.

Transfers to local governments: subsidies for investments to mitigate inequalities in resources of local governments for health services

Payments of social insurance contribution on behalf of the poor

Payments to NGOs operating health centres for drug addicts

Transfers to cover the deficit of the social health insurance scheme

Tax allowances to people buying voluntary health insurance

Payments for voluntary insurance fee for government employees

Payments to operate the kindergarten of the Ministry of Health

Transfer of funds from foreign NGO to local NGOs for a HIV/AIDS prevention program

Ministry of Defence

Payments for operating the separate health system of the army

Health accountants have to identify which of these transactions should be accounted as spending by **governmental health financing schemes (HF.1.1.1).**

As already discussed, in analysing the government health specific spending the starting point is to distinguish between the following types of transactions:

Transactions by governmental financing schemes (revenue-raising, pooling and purchasing)

Transactions related to government health-related functions (HCR.1, HCR.2)

Transactions related to resource-generation (human and physical capital and technology)

Providing revenues by the government to other financing schemes

Transactions made as an intermediary institution (e.g., between foreign NGO and local NGOs)

Non-health spending by the government units acting as financing agent

Box 1. Table 4.3 shows the activities of the government in according to these categories of transactions.

Table 4.3 SHA-based categorization of the health care budget items of the Government (example)

	Transactions by governmental financing schemes	**Transactions related to HCR.1, HCR.2; or resource-generation**	**Providing revenues to other financing schemes**	**Serving as an intermediary institutions**	**Non-health spending by a government unit acting as financing agent**
Payments for operating National Ambulance Service	HF.1.1.1 Central governmental schemes				
Payments to hospitals owned by the government	HF.1.1.1 Central governmental schemes				
Payments to health centres operated by private organisations	HF.1.1.1 Central governmental schemes				
Payments for public health programs financed through an application. Applicants must cover certain part of the costs.			FS.1.4 Other transfers from government domestic revenues		
Transfers to local government for investments in local hospital		Transfers to local governments: subsidies for investments			
Payments of social insurance contribution on behalf of the poor			FS.1.2. Transfers by government on behalf of specific groups		
Payments to NGOs operating health centres for drug addicts			FS.1.4. Other transfers from government domestic revenues		
Transfers to cover the deficit of the social health insurance scheme			FS.1.1, Internal transfers and grants FS.1.3 Subsidies		
Tax allowances to people buying voluntary health insurance			FS.1.2. Transfers by government on behalf of specific groups		
Payment for voluntary insurance fee for government employees			FS.1.2. (?) Transfers by government on behalf of specific groups Or: FS1.4 (?) Other transfers		
Payments to operate the kindergarten of the Ministry of Health					Non-health spending
Transfer of funds from foreign NGO to local NGOs for a prevention programme				Serving as an intermediary institutions	
Payments for operating the separate health system of the army	HF.1.1.1 Central governmental schemes				

CHAPTER 5 INTERPRETING "PUBLIC" AND "PRIVATE" UNDER SHA 2011

This chapter provides a more detailed explanation and a numerical example for the interpretation of "public" and "private" under SHA 2011. Two expenditure aggregates are proposed. The first focuses on spending by financing schemes with the following aggregates: expenditure by government schemes and compulsory contributory health financing schemes, and expenditure by voluntary health financing schemes. The second approach focuses on the revenues of financing schemes: health spending from public and compulsory private funds, and health spending from voluntary funds. The main difference between the two approaches is the treatment of government transfers to voluntary financing schemes.

143. A key indicator in health care financing is the public-private split. Historically, there have been difficulties in clearly defining and interpreting what "public" and "private" refers to. [29] The SHA 2011 financing framework attempts to clarify this distinction by providing a clear picture of the structure of spending on health care under current complex financing arrangements.

144. SHA 2011 proposes a new approach for accounting the mix in health financing. It uses the concept of "public" and "private" in financing from a perspective of regulation (decision-making). In this sense, it is preferable to use the terms "**compulsory**" and "**voluntary**" in financing, and to use the terms "public" and "private" only for institutional forms.

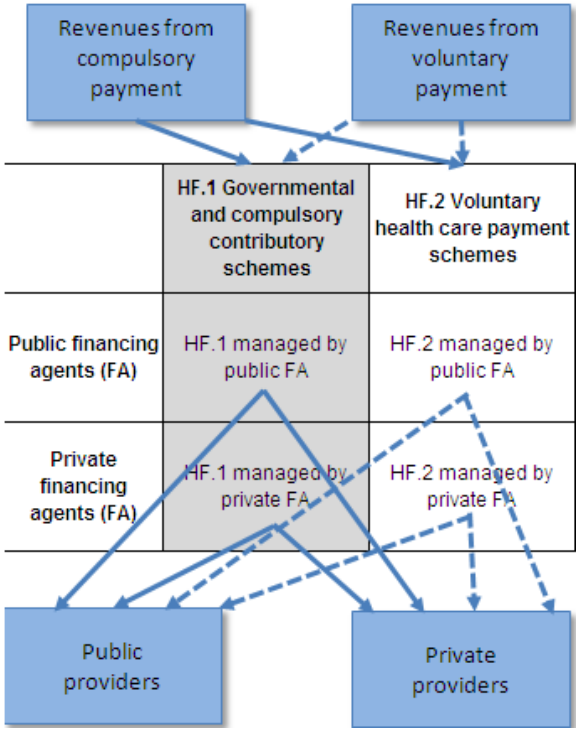
145. Many health systems have a complex mix of "public" and "private" roles cutting across the different functions and institutions. "Public" and "private" can refer to the collection of funds, the redistributed funds, the revenues of the schemes, the payments by the schemes, the financing agents and the providers. Furthermore, public-private partnerships can be found in several areas in health systems. Figure 5.1 shows a simplified presentation of the public-private mix in health systems.

146. This chapter discusses three issues:

- The interpretation and accounting of "public" and "private";
- Accounting of cost-sharing;
- Accounting government financial incentives and advantages relating to offering or buying voluntary health insurance.

[29] This ambiguity is in part because the terms "public" and "private" can be (and are) used with different meanings in health statistics. SHA 1.0 defined the private sector as follows: "This comprises all resident institutional units which do not belong to the government sector." If this definition were strictly applied, compulsory private insurance and social insurance schemes executed by private insurance companies would be reported under private expenditure, together with voluntary insurance and OOP. (This obviously would not be appropriate.)

Figure 5.1 A simplified presentation of the public-private mix in health systems



The interpretation and accounting of "public" and "private"

147. SHA 1.0 conceptualised "public" and "private" in an institutional sense, that is, whether the financing agent is a public or private institutional unit, or whether the financial resources are provided by a public or private institutional unit. This approach is not suited to the complex arrangements of health financing, because the key distinguishing criteria is not the institutional forms but the nature of the regulation establishing whether participation or payment is compulsory or voluntary. There is a mismatch between this and the institutional approach. For example, private institutional units (e.g., households) are obliged to contribute to publicly regulated funds (e.g., social health insurance schemes) but may also contribute to voluntary financing schemes or pay directly for services at their discretion.

148. Hence, SHA 2011 adopts two approaches:

- From the perspective of financing schemes, the main distinguishing criterion is whether the participation in a scheme is compulsory or voluntary;
- From the perspective of the types of revenues, the key distinguishing criterion is whether the payment or contribution is compulsory or not.

149. Concerning the accounting of health care financing, it is therefore possible to calculate aggregates using either of these approaches.

- Calculation of expenditures by financing schemes has the following two major expenditure aggregates under SHA 2011:

1) Expenditure by governmental schemes and compulsory contributory health financing schemes

(Two Possible sub-aggregates: (i) expenditure by governmental and social health insurance schemes; and (ii) expenditure by compulsory private schemes)

2) Expenditure by voluntary health financing schemes

- Calculation of expenditures by the revenues of financing schemes has the following two major aggregates:

1) Health spending from public and compulsory private funds

(Two possible sub-aggregates: (i) spending from public funds; and (ii) spending from compulsory private funds)

2) Health spending from voluntary funds

150. The approach taken depends on the purpose of the analysis. In the first approach, the division is at the level of schemes and follows the HF division. This approach does not account for the sources of funds but gives information on the extent of public regulation of the healthcare system. The second approach, however, focuses on dividing the revenues of the financial schemes. It thus provides information on publicly or privately regulated revenue.

Example

151. The SHA 2011 Manual provides two tables with the components of the above mentioned aggregates. Here, a hypothetical example is provided for illustration.

- Table 5.1 shows the summary data on HFxFS for COUNTRY (A)
- Table 5.2. shows expenditure by governmental, compulsory contributory and voluntary health financing schemes for COUNTRY (A)
- Table 5.3. displays health spending from public, compulsory private and voluntary private funds for COUNTRY (A)

152. The categories (expenditure aggregates) of "Expenditure by government schemes and compulsory contributory health financing schemes" and "Expenditure by voluntary health financing schemes" do not take into account that voluntary health financing schemes may receive revenues from government. For example, the whole spending by NPISHs' financing schemes is accounted as private expenditure - although the revenue of NPISHs' financing schemes may come partly from government transfers. On the contrary, under the approach based on revenues of financing schemes, all spending from government general revenues on health are accounted as spending from public funds, including transfers to private financing schemes.

153. In the example, the difference between the two approaches means that, according to the approach based on expenditure by financing schemes, the share of expenditure by government schemes and compulsory contributory financing schemes is 75.8% of total expenditure, while according to the approach based on revenues, the share of public and compulsory private funds spent on health care is 78% of total health spending.

Under the approach based on revenues, the following categories can also be defined:

- **Public funds** include: (i) funds allocated from general revenues of government for governmental schemes, (ii) funds created from social insurance contributions, (iii) transfers allocated from general revenues of government to health financing schemes other than governmental schemes (grants, subsidies and transfers to NPISHs, etc.), and (iv) foreign revenues of government allocated to health care.
- **Compulsory/Mandatory private funds** are funds created from compulsory private insurance premiums and payment for compulsory MSAs). The explicit identification of these types of funds enables the analyst to group together these funds with public funds (as showed in Table 4.3) or group them together with voluntary private funds. The decision on which approach is applied will depend on the nature of the analysis to be performed.

  Voluntary private funds, including all other funds.

Table 5.1 Revenues of health care financing schemes by type of revenues, COUNTRY (A)

	Revenues of financing schemes	**FS.1**	FS.1.1	FS.1.2	FS.1.3.	FS.1. 3	**FS.2**	**FS.3**	**FS.4**	**FS.5**	**FS.6.**	**FS.7**	**All FS**
Financing schemes		**Transfers from government domestic revenues**	Internal transfers and Grants	Transfers by government on behalf of specific groups	Subsidies	Other transfers from government domestic revenues	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Compulsory prepayment (other than FS.3)**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**	**All revenue of financing schemes**
HF.1	**Governmental schemes and compulsory contributory health financing schemes**	**120**	**120**					**650**	**90**				**860**
HF.1.1	Governmental schemes	120	120										120
HF.1.2	Compulsory contributory health financing schemes							650	90				740
HF.1.2.1	Social health insurance							650					650
HF.1.2.2	Compulsory private health insurance								90				90
HF.1.3	Compulsory private health insurance (other than LTC)												
HF.2	**Voluntary health care payment schemes**	**25**			**10**	**15**				**80**	**20**		**125**
HF.2.1	Voluntary health insurance schemes	10			10					80			90
HF.2.2	NPISH financing schemes	15				15					10		25
HF.2.3	Enterprises financing schemes										10		10
HF.3	**Household out-of-pocket payment**										**150**		**150**
HF.4	**Rest of the world financing schemes**												
HF	**All financing schemes**	**145**	**120**		**10**	**15**		**650**	**90**	**80**	**170**		**1135**

Table 5.2 Expenditure by government, compulsory contributory and voluntary health financing schemes

	Financing Schemes	Mln NCU	Major expenditure aggregate	Mln NCU	%
HF.1.1	Governmental schemes	120	Expenditure by government and compulsory contributory health financing schemes	860	75.8%
HF.1.2.1	Social health insurance schemes	650			
HF.1.2.2	Compulsory private insurance schemes	90			
HF.1.3	CMSA	0			
HF.2.1	Voluntary health insurance schemes	90	Voluntary private expenditure	275	24.2%
HF.2.2	NPISHs financing schemes	25			
HF.2.3	Enterprises financing schemes	10			
HF.3	Household out-of-pocket payment	150			
All HF	**All financing schemes**	**1135**		**1135**	**100.0%**

Table 5.3 Health spending from public, compulsory private and voluntary private funds

	Revenues of financing schemes	Mln NCU	Major funding aggregates	Mln NCU	%
FS.1	Transfers from government domestic revenue	145	Public and compulsory private funds	885	78.0%
FS.2	Transfers distributed by govt. from foreign origin	0			
FS.3	Social insurance contributions	650			
FS.4	Compulsory prepayment (other than FS.3)	90			
FS.7.1.1/2	Bilateral/multilateral financial transfers				
FS.7.2.1.1/2	Bilateral/multilateral aid in goods				
FS.7.2.2	Direct foreign aid in services (incl. TA)				
FS.5	Voluntary prepayment	80	Voluntray private funds	25	22.0%
FS.6	Other domestic revenues n.e.c.	170			
FS.7.1.3	other direct foreign financial transfers				
FS.7.2.1.3	Other direct foreign aid in goods				
FS.7.3	Other foreign transfers (n.e.c.)				
All FS	**All revenues of financing schemes**	**1135**		**1135**	**100.0%**

An example of accounting health expenditures according to schemes versus institutional units

154. The changes in the interpretation of "public" and "private" is an integral part of the wider conceptual change under SHA 2011 which interprets the main categories of health financing as financial schemes (instead of institutional units). To highlight the difference between financing schemes and financing agents, a simplified example (Table 5.4) is provided with Country (A), (B) and (C); the numbers in brackets show the share of the expenditure concerned in total health expenditure:

- The financing system of Country (A) consists of the following elements: a social insurance scheme managed by a centralised government agency (70%), a voluntary health insurance managed by insurance corporations (5%) and out-of-pocket payments (25%);
- The financing system of Country (B) consists of a social insurance scheme (70%) under which individuals pay the same percentage of their income as insurance contributions and have access to the same basket of services as in Country (A). The only difference is that the social insurance scheme has a decentralised institutional setting in which the insured persons can choose between a government agency and private insurance corporations to manage the operation of their social insurance. At the same time, private insurance corporations also offer voluntary health insurance. The payment by the private insurance corporations under the social insurance scheme amounts to 40% of total expenditure, while their payment under the voluntary insurance amounts to 5% of total expenditure.
- In Country (C), voluntary private insurance provides the primary coverage (50%), and insurance companies apply risk-related premiums. The Government has a programme for the poor (15%), and out-of-pocket payments amount to 35% of total health expenditure.

155. According to financing schemes, Country (A) and (B) have the same structure, with the dominant role of social insurance providing access to the whole population. Public expenditure amounts to 70% in both countries. This approach, however, overlooks the different institutional settings.

156. According to financing agents, the spending structure of Country (B) resembles more the spending structure of Country (C) as the share of private expenditure (spending by insurance companies) amounts to 70% compared to 30% for Country (A). In Country (B) every resident has access to basic health care (as in Country A), while in Country (C) a great part of the population may not be able to afford to buy voluntary insurance. According to financing agents, public expenditure in Country (B) amounts only to 30%, while the spending comes from funds raised under social insurance amounting to 70% of total resources. Moreover, private insurance company spending cannot be split much is spent under social insurance and how much is spent under voluntary insurance.

157. This simple example shows that international comparison of health expenditures based on accounting according to financing agents could be misleading. A key health policy issue is to determine the role of government intervention in ensuring access to care for the population, as well as the financing arrangements ensuring access to care for the whole population (or specific population groups) from the financing arrangements that individuals voluntarily choose.

158. A possible way of presenting both the financing schemes and the financing agents is by creating sub-categories of financing schemes according to the types of institutional units involved in their operation.

Table 5.4. An illustration for the difference between accounting health expenditure according to financing schemes versus financing agents

Accounting health expenditure according to financing schemes

		(A)	**(B)**	(C)
HF.1.1	Governmental schemes			15
HF.1.2.1	Social health insurance schemes	70	70	
HF.2.1	Voluntary health insurance schemes	5	5	50
HF.3	Household out-of-pocket payment	25	25	35
	'Public' expenditure according to HF	**70**	**70**	**15**
	'Private' expenditure according to HF	**30**	**30**	**85**

Accounting health expenditure according to financing agents

		(A)	**(B)**	(C)
FA.1	Government	70	30	15
FA.2	Health insurance corporations	5	45	50
FA.5	Households	25	25	35
	'Public' expenditure according to FA	**70**	**30**	**15**
	'Private' expenditure according to FA	**30**	**70**	**85**

General government versus Public sector

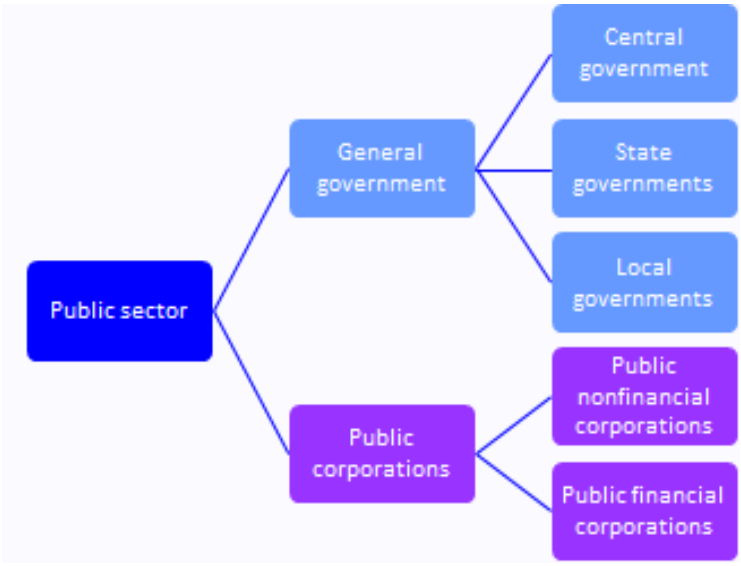
159. Although the emphasis in this chapter is on the separation according to the criterion of participation (in the case of schemes) or contribution (in the case of revenues to schemes), a discussion of the sectoring of the institutions involved is also relevant, and in particular, the distinction between the government sector and the public sector.

160. While the starting point for SHA 2011 is the National Accounts sectoring into government, corporations (financial and non-financial), household and NPISH sectors, it is important to note that the broader 'public' sector, as defined in Government Finance Statistics (GFS) comprises, in addition to the government sector, public corporations. This includes corporations subject to the control by a government unit or other public corporation. (Figure 5.2)

161. For countries that have a fragmented public health sector, the differences can be important and may give a distorted view. In addition, certain reporting rules may apply, e.g. in the case of

European Union member states, on the expenditures of government which can have consequences on what is included and excluded.

Figure 5.2 The public sector and its sub-sectors



Source; Government Finance Division, IMF Statistics Department

Treatment of cost sharing

162. Coverage by a third-party financing scheme (insurance or government scheme) has three components: population coverage, the service package covered and the share of the costs of the given services covered by the scheme. Consequently, cost-sharing by patients should be considered a component of out-of-pocket payments and not expenditure by the third-party financing scheme. [30] The conception, monitoring and assessment of financial protection require a clear distinction between the share of costs covered by compulsory insurance (or a government scheme) and the share of the costs paid by the patients. Obviously, high cost-sharing by patients jeopardises financial protection. Thomson *et al* (2009) emphasized that: "Several countries have made efforts to expand population coverage. However, the scope and depth of coverage are as important as its universality and the trend in some countries to lower scope and depth undermines financial protection". (p.xxi)

163. Voluntary insurance may reimburse cost-sharing by the patient. This case should be treated similarly to the case when voluntary insurance reimburses the bill of a service not covered by compulsory insurance. The payment is considered as expenditure by the voluntary insurance. Consequently, the part of cost-sharing reimbursed by voluntary insurance should be accounted as expenditure by voluntary insurance and should not be taken into consideration under OOP payment by the households. This treatment ensures that a proper picture of financial protection is provided. It should, however, be noted that the characteristics of the coverage by the governmental scheme or insurance determine the households' cost-sharing which is a component of the households' out-of-pocket payment (OOP). The full cost of services or goods concerned accounts for its two payment components: the third-party payer and the OOP. As the full cost of the services or goods concerned is also important information, the following memorandum items are included in the classification: governmental schemes and compulsory contributory health insurance schemes together with cost sharing (HF.1+HF.3.2.1), and voluntary health insurance schemes together with cost sharing (HF.2+HF.3.2.2).

[30] Cost-sharing component is mandatory and related to the scheme and as such part of the complete scheme. The scheme dictates the amounts or shares to be paid just as the scheme dictates the premiums or contributions or benefits.

164. Care should be taken in accounting for user charges. For example, user charges paid by patients at a facility should be accounted as household payments (HF.3). However, if they are returned to the financing scheme, the total expenditure by the scheme should be net of these charges.[31]

Possible measurement problems

Adhering to the general rule of accounting on an accrual basis

165. Since insurance reimbursements often take place in a different time period to that of the original household out-of-pocket payment, this can cause a measurement error. However, in line with accrual methodology, all payments should be counted as occurring in the period in which the actual medical service was provided, albeit accepting that it may be difficult to determine from the available insurance data to which period the actual insurance expenditures relate.

Accounting government financial incentives and advantages relating to offering/buying voluntary health insurance

166. Governments may encourage the offer and purchase of VHI policies in a variety of ways (OECD, 2004). From an accounting perspective, all forms can be considered as an arrangement in which the government shares the costs of purchasing insurance. Consequently, in an economic sense, part of the revenues of the voluntary health insurance is ultimately paid by the government. Therefore, it is proposed to account all forms of tax incentives and financial advantages – in the form of tax credits or tax allowances - provided by the government as transfers from government domestic revenue (FS.1). For example, individuals may deduct part of the insurance fee they paid for voluntary insurance from their taxable income (tax allowance or deduction) or in the personal income tax due (tax credit). From an accounting point of view, revenues of the voluntary health insurance scheme were partly provided by the government. In this case, individuals (households) are considered as intermediary organisations between government providing revenues to VHI schemes. In general, under SHA 2011 all flows are accounted on an accrual basis. Therefore, the rules of accrual-based accounting should also be applied in this case. This requires a specific estimation, because the concrete amount of tax incentives that relates to the purchase of insurance in year *t* is provided to individuals only in year (*t+1*). (One possibility is to estimate the present value (in year *t*) of the tax incentives given in year (*t+1*)).

167. Depending on the specific form, tax incentives and other financial advantages by the government can be accounted as FS.1.2, FS.1.3 or FS.1.4. However, the availability of data on tax incentives and other financing advantages may be very limited, hindering the possibilities of the actual accounting.

168. A distinction should be made between tax advantages on the purchase of health insurance detailed above and the tax deductions or credits related to the actual purchase of health care goods and services. In this latter case, this is to be treated as a cost-sharing arrangement with a reduction in the Household out-of-pocket payment (HF.3) and the equivalent increase in the payment by, for example, Government schemes (HF.1.1). Again, there are obvious challenges in imputing the part due to tax credits or allowances because of data availability from tax records and lags in reporting.

[31] See Producer Guide 10.15 for more details.

CHAPTER 6 ACCOUNTING FOREIGN AID

This chapter provides a conceptual framework for accounting foreign aid, in the context of a comprehensive view of the domestic-foreign mix in health care financing and provision. It discusses the main steps in the accounting of foreign aid, including important methodological problems. Included is also a discussion of the link between SHA 2011 and DAC statistics[32].

169. Foreign assistance and other foreign resource flows can play an important role in financing health care in many lower income countries. Health accounts are expected to provide a transparent picture of foreign flows into a country's health system, as well as the institutions involved. The accurate tracking of foreign resource flows is of great importance from the perspective of the recipient country and the donor organisations.

170. As discussed in Chapter 4, foreign aid can be managed through the central government budget, provided directly to financing schemes (financing agents) other than governmental schemes, or provided directly to health care providers.

171. Regarding foreign aid, the SHA 2011 accounting framework for financing:

- intends to track, as much as possible, the route of total foreign resource flows[33] in the domestic health care system;
- includes not only health-specific aid, but also an estimation (imputation) of the part of general budget aid that can be considered as used for health purposes and other health-specific flows (without aid purposes);
- allows the development of a correspondence to DAC statistics;
- makes the distinction between the following different types of foreign involvement (types of flows and types of institutional units, types of providers): foreign institutions providing resources, foreign revenues of financing schemes (direct and indirect), foreign institutions providing resources, acting as financing schemes (Rest of the World – RoW – financing schemes), and managing RoW financing schemes and foreign providers providing care.

172. Concerning data sources, priority should be given to national databases. However, international databases such as the OECD DAC (Development Assistance Committee) database may also help international comparability. Ideally, it would be of value to use both national and international sources and triangulate the results.

173. The main tasks of accounting foreign aid are as follows:

Task 1: A qualitative description of foreign involvement in health financing

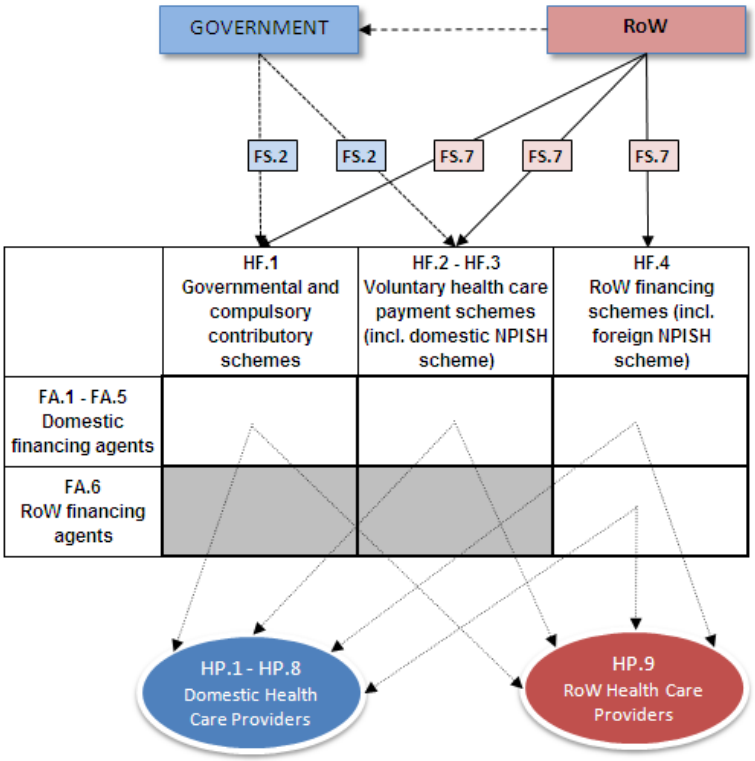
174. The foreign involvement in health financing in a country can be better understood if the starting point is a comprehensive view of the domestic-foreign mix in health care financing and

[32] Development Assistance Committee. The OECD Development Co-operation Directorate as a Secretariat of DAC collects data on aid and other international resource flows to developing countries.

[33] The discussion in this chapter is restricted to foreign aid, rather than all funds received from abroad, e.g. payments under foreign insurance or from foreign households.

provision. Figure 6.1 shows a simplified picture of the flows of foreign resources in the health system and the institutional units involved.

Figure 6.1 A simplified graphical representation of foreign flows and institutional units in the health system



175. The upper part of the figure shows how financing schemes raise their revenues. The table illustrates the possible main types of financing schemes, and their management by either domestic or RoW financing agents. The bottom part shows how domestic and foreign providers deliver health care services to the population.

176. As discussed in Chapter 4, financing schemes can raise their revenues directly from the primary owners of income, or as a result of the allocation of the general revenues of the government or specific NGOs. In the latter case, the government (or the NGO) first raises general revenues for their overall activities from the primary owners of income. It then allocates the revenues among its different spending areas, including health financing schemes. These cases require clear, transparent accounting. It should be noted that the approaches taken by SHA 2011 differ in the case of the government and the NGOs acting as providers of revenues. (See Chapter 7)

177. Some of the flows illustrated by Figure 6.1 are explained through specific examples in Table 6.1. Such a table can be useful to provide a general picture of foreign involvement in the health care system.

Table 6.1 Examples for the mix of domestic and foreign flows and institutional units in the health system

Description of foreign involvement	Example
Foreign revenues – Governmental scheme – Domestic financing agent - Domestic health care providers	Governmental scheme can receive general budget support of foreign origin, part of which is used for health purposes (accounted as revenue of governmental scheme).
Domestic revenues – Government scheme - Foreign financing agent – Foreign health care providers	Two governments have a bilateral agreement such that payments for the treatment of individual residents in the other country will be settled between the two

	government agencies responsible for health care finance.
Domestic revenues – Voluntary health care payment scheme - Domestic financing agents –Foreign health care providers	Payments by Voluntary travel insurance to foreign providers.
Foreign revenues – RoW financing scheme – RoW financing agent - Foreign health care providers	A foreign NGO finances a vaccination programme and the programme is carried out by another foreign NGO in the recipient county

Specific cases

Foreign aid in the form of conditional cash transfers

178. Conditional cash transfers by government (CCT) are payments with a conditionality of a specific action by the recipients; i.e., individuals receiving cash payments are required to undertake a specific action, for example, attendance at primary care centres for preventive interventions (childhood immunization and pregnancy care, such as antenatal visits and nutrition).[34]

179. A foreign donor may provide aid to the government with the request to use it (or part of it) for Conditional Cash Transfers (CCT), or, specifically, RoW financing schemes can be CCT. As discussed in Chapter 7 of the SHA 2011 Manual, CCT is perceived as a health-specific financing scheme and not as a source of household out-of-pocket payments. Hence, if CCT is implemented by the government using foreign resources, it should be accounted as FS.2xHF.1.1 (a specific sub-category can be created, if required). If the foreign donor (e.g., foreign NGO) not only provides aid but also implements the programme, it should be accounted as FS.7.1.3xHF.4 (e.g., HF.4.2.2.2 Foreign development agencies scheme).

180. In a more complex example, a foreign agency promotes prenatal consultations by offering free delivery for women purchasing a delivery kit (consisting of materials and basic medical goods for a safe delivery). Any funds collected through the sale of the kits may be used towards the costs of the health centre. First, the prenatal consultation (HC.6.4) delivered by the health centre is financed, either partially or entirely, by the foreign NGO (HF.4)[35] perhaps through direct foreign aid (FS.7). The delivery kit itself is not a part of the prenatal service, rather medical goods (HC.5) or as an input to the subsequent delivery service (HC.1.1) and is partly financed by households (HF.3/FS.6.1)[36] with the provider being the health unit.

Task 2: Identification of data sources for foreign revenues of financing schemes

181. Two types of data sources exist for foreign aid revenues of financing schemes:

- executed data from the recipient country's budget (preferred source)
- international databases on donors' disbursements data (OECD DAC statistics; IHME database; AidData project, etc,.)

182. For a comprehensive tracking of aid-funded expenditure, government, private NGO and donor agencies in the country should be consulted. Data from the former are accessible from the

[34] Over the past few years, several Latin American and African countries have introduced CCT programmes to encourage healthcare utilisation and health-seeking behaviour. For more detail, see: http://apps.who.int/rhl/effective_practice_and_organizing_care/Support3/en/

[35] However, if the programme is carried out by the NGO at the local level it can also be treated as part of the domestic economy. In that case the financing scheme may be HF.2.2.2.

[36] The fact that the payment by the household is an integral and 'mandatory' part of the overall service means that it may be considered as a cost-sharing part of the NGO financing scheme. In such a case a new sub-category of cost-sharing could be created e.g. HF.3.2.3. Cost sharing with NPISH.

Ministry of Finance and the Ministry of Health (office of budget or planning). Countries are increasingly requesting resident donor agencies to report their expenses and disbursements, down to the actual expenditure. Several tools are available and used in counties, generically labelled Aid Information Management System (AIMS). When this is not the case, countries will need to survey the relevant agencies.

183. It is important to consider all sources (bilateral, multilateral, foundations, NGOs), all types of flows (earmarked and budget support), and favour data on aid-funded expenditures rather than donors' aid disbursements.

184. An important difference between the scope and boundary of OECD DAC statistics and SHA 2011 should be emphasised. Aid to health in DAC statistics includes only aid earmarked to health purposes. **SHA 2011 considers not only aid dedicated to health, but also a share of foreign general budget support used for health.**

Task 3: Decision on the country-specific application of SHA 2011 for accounting foreign aid

185. Based on the qualitative description of the health system (Chapter 2) and the analysis of the correspondence between SHA 2011 and DAC statistics, the following decisions should be made:

- Which FS, HF and FA categories are relevant for the country;
- Whether country-specific sub-categories are developed under any category of the SHA 2011 classifications;
- Whether some specific tables are to be prepared for the analysis of foreign aid (for example, similar to Table 6.3);
- Whether a country-specific boundary is defined for a specific analysis of foreign aid.

Task 4: Producing and adjusting aid related estimates

186. Several specific technical questions need clarification before producing aid-related estimates, including the following:

- Separation of General and Sector budget support into what is accounted under FS.2 and what is accounted under FS.7.
- How to interpret and calculate debt cancellation. Debt cancellation is a difficult subject to treat as it can be perceived as foreign funds made available to the government (since they don't need to reimburse their debt) or as government resources (since it is funds that they collected and will not be used for paying foreign debt). SHA 2011 treats cancelled debts as if foreign funds were transferred to the government, which would then be used to pay the debt back to the donors. It is therefore as if two transactions were taking place, with revenues from abroad and used by the government (FS.2) and the schemes paying for services (HF.1). For countries where budget support and debt cancellation is high, it may be interesting to break down FS.2 into categories highlighting the respective shares. As is the case for budget support, the share of debt cancellation going to health care needs to be estimated (unless it is earmarked debt). There are two approaches: using the share of total government expenditure going to health, or the share of government expenditure for poverty alleviation going to health (which could be estimated by deducting spending on the military or other non-poverty related lines).
- Bilateral or multilateral aid (e.g., GFATM[37]: Is the donor the government giving funds to GFATM or is it GFATM?): Because agencies such as GFATM are pooling funds into one common budget from various sources, they become the agent providing revenues to schemes.

[37] Global Fund to Fight AIDS, Tuberculosis and Malaria

- Types of aid: financial resources, in-kind aid, technical support, administrative costs. Clarification is needed as to what to account in these cases.
    - Valuation of in-kind and technical support: According to GFS, grants in kind should be valued at current market prices. If market prices are not available, then the value should be the explicit costs incurred in providing the resources or the amounts that would be received if the resources were sold. In some cases, the donor and the recipient may view the value quite differently. SHA 2011 deviates from the GFS and records the value applied by the recipients as the health expenditure. In these cases, the valuation from the viewpoint of the donor is, however, included as a memorandum item (FSR.2), in order to make the difference between the valuation by the donor and the recipient transparent.
    - Accounting for administrative costs: Only administrative costs of the financing schemes residing in the recipient countries should be accounted. (See Chapter 4)
- To separate aid from loans from concessional loans: What is ODA and should aid be distinguished from other foreign flows of funds? Concessional loans should be considered under foreign grants (FS.7.1).
- Scholarships sponsored by foreign entities to be recorded as FS.7.1.
- Multiple intermediations: It is often difficult to identify what is the original transfer to the scheme. Let's consider the example of GFATM again. A government bilaterally funds GFATM, which then transfers resources to the Ministry of Finance, which in turn transfers the resources to a secondary recipient, an NGO. Ultimately, the units serve as transitory intermediates, neither funding expenditure with their own resources or resources they would have pooled, nor acting as financing schemes purchasing goods or services. Therefore, they should not be accounted for in SHA 2011. However, each transfer entails costs (either conversion costs or administrative costs). These costs should be accounted for as expenses by the scheme to HC.7.2 insofar as the costs are created in the domestic economy.
- Remittances (households' revenues from family members working abroad) and revenues from foreign NGOs should be accounted under FS.7.1.3. If other direct foreign financial transfers, national sub-categories of FS.7.3 can be created.

Task 5: Extracting the relevant part of SHA tables, including the relevant working tables

187. See Chapters 2 and Annex 1.

Task 6: Evaluating total foreign resource flows to the health sector

188. For policy purposes it is usually of greater importance to know the total foreign resource flows rather than the breakdown. To understand the <u>total</u> foreign resource flows, it is necessary to sum up the following revenue classes:

FS.2 Transfers distributed by government from foreign origin
FS.7 Direct foreign transfers

This aggregate is suggested as a Reporting Item to the FS classification, namely FS.RI.2 Total foreign revenues.

Correspondence between SHA 2011 and international aid statistics (DAC)

189. The OECD DAC (Development Assistance Committee) database distinguishes between:

- **Commitments**: refers to the funds set aside to cover the costs of projects, which can span several years;

- **Disbursements**: refers to the placement of resources at the disposal of the recipient. Disbursements record the actual international transfer of financial resources, or of goods or services valued at the cost to the donor.

190. DAC statistics also make a distinction between:

- **outflows of resources from donor countries** to recipient countries and multilateral agencies; and
- **receipts of developing countries.** These comprise donors' bilateral transactions with the recipients (ODA, OOF[38] and private) and outflows from multilateral agencies (concessional and non-concessional).

The concept of revenues of financing schemes corresponds more closely to the concept of disbursement received by the developing country in the given year under DAC statistics. (Data on "Receipts of developing countries")

191. DAC statistics are categorised by **Type of finance**; **Sector/purpose**; and **Type of aid.** The DAC sector classification contains health (health general and basic health); and aid to health is sub-divided in 2 sectors and 17 sub-sectors (OECD-DAC, 2009)

Table 6.2 Type of finance in DAC statistics and Revenues of financing schemes in SHA 2011

Official Development Assistance (ODA)	FS.2	Transfers distributed by Government from foreign origin
	FS.7	Direct Foreign transfers Direct bilateral financial transfers Direct multilateral financial transfers Direct bilateral aid in goods Direct multilateral aid in goods Direct foreign aid in kind: services (including TA)
Other official flows (loans from the government sector)	FSR.1.1	Loans taken by government
Private flows at market terms	FS.7.1.3 FS.7.3	Other direct foreign financial transfers Other direct foreign transfers (n.e.c.)
	FSR.1.1	Loans taken by government
	FSR.1.2	Loans taken by private organisations
Private grants from NGOs and foundations	FS.7.1.3	Other direct foreign financial transfers
	FS.7.2.1.3	Other **direct** foreign aid in goods
	FS.7.2.1.3	**Direct** foreign aid in kind: services (including TA)
	FS.7.3	Other **direct** foreign transfers (n.e.c.)

192. The categories of the type of finance in DAC statistics:

- **Official Development Assistance (ODA):** Grants or loans from public funds to promote the economic development and welfare of developing countries. To qualify as ODA, loans must have a ***grant element*** of 25% or more;
- **Other official flows** (OOF), comprising (i) loans from the government sector which are for development and welfare but not sufficiently concessional to qualify as ODA; and (ii) grants and loans from the government sector not specifically directed to development or welfare purposes (e.g. official export credits);
- **Private flows at market terms** (e.g. foreign direct investment, bank loans); and
- **Private grants** from NGOs and foundations

[38] Other Official Flows

193. Table 6.3 shows the relationships between DAC statistics and SHA 2011 in more detail. The correspondence between the Type of aid categories of DAC and the FS categories of SHA 2011 is shown in the first four columns. The fifth column shows the financing schemes that may receive the given financing aid. The last column provides or refers to some explanations.

Table 6.3 Correspondence between SHA 2011 and Type of aid in DAC statistics

	CRS/DAC	**SHA 2011**			Notes
	Type of aid (CRS/DAC)		Revenues of health financing schemes	Possible financing schemes	
A	Budget support				
A01	General budget support	FS.2	Transfers distributed by government from foreign origin	Governmental scheme	In the absence of information to the contrary, it might be assumed that only governmental health schemes receives revenues from foreign general budget support (1)
A02	Sector budget support	FS.7	Direct Foreign transfers (Mainly: Direct Bilateral financial transfers or Direct Multilateral financial transfers	Governmental scheme	Note (2)
		FS.2	Transfers distributed by government from foreign origin	NPISH financing schemes	Note (2)
B	Core contributions and pooled programmes and funds				
B01	Core support to NGOs, other private bodies, PPPs and research institutes	FS.7	Direct Bilateral financial transfers Direct Multilateral financial transfers **Direct** Bilateral aid in goods **Direct** Multilateral aid in goods	NPISH financing schemes Rest of the world financing schemes	B01 refers to funds that are paid over to NGOs (local, national and international) for use at the latter's discretion, contribute to programmes and activities which NGOs have developed themselves, and which are implemented with their own authority and responsibility (Note (3)
		FS.6.3	Other revenues from NPISH n.e.c.	NPISH financing schemes	Support accounted under B01 may go to domestic NGO that only raises funds both from domestic and foreign institutions and then supports (transfers money to) other NGOs acting as financing schemes (Note (4))
B02	Core contributions to multilateral institutions				The recipient multilateral institutions pool contributions so that they lose their identity and become an integral part of its financing assets. Only the next phase of the flows is reported under SHA 2011 (FS x HF) Note (5)
B03	Contributions to specific-purpose programmes and funds managed by international organisations (multilateral, INGO)	FS.7	Direct Foreign transfers (subcategory depends on the nature of the contribution)	Rest of the world financing schemes	
B04	Basket funds/pooled funding	FS.7.1.2.	Direct Multilateral financial transfers	NPISH financing schemes	

		FS.7.1.2.	Direct Multilateral financial transfers	Rest of the world financing schemes	
C	Project-type interventions				
C01	Project-type interventions	FS.7	Direct Bilateral financial transfers Direct Multilateral financial transfers Direct Foreign aid in goods	Governmental financing schemes	
				NPISH financing schemes	
				Rest of the world financing schemes	
D	Experts and other technical assistance	FS.7.2.2.	**Direct** Foreign aid in kind: services (including TA)		
E	Scholarships and student costs in donor countries	FS.7.3	Other **Direct f**oreign transfers (n.e.c.)		
F	**Debt relief**	**FS.2**	**Transfers distributed by Government from foreign origin**	**Governmental financing schemes**	Note(6)
		FS.7.1.1 FS.7.1.2	Direct Foreign transfers	Governmental financing schemes	If the loan concerned is health-specific
G	Administrative costs n.i.e.				Not accounted under SHA 2011

Notes

(1) For simplicity, it is assumed that only governmental health financing schemes receive revenues from foreign general budget support. Transfers provided by government to other financing schemes come from domestic sources or foreign support earmarked to health.

(2) Sector budget support received by the government may be used in two ways: for the purposes of government operated health programmes and health facilities (accounted under SHA 2011 as Direct Foreign transfers: a revenue of governmental financing schemes), or for the purpose of supporting from this fund health programmes of NPISHs (accounted under SHA 2011 as **FS.2 Transfers distributed by Government from foreign origin.**

(3) Core support is provided to foreign NGO (A), which uses part of these funds to support foreign NGO (B) (not resident in the country) in implementing a vaccination programme in the recipient country. It is accounted as Direct bilateral/multilateral financial transfer (FS.7.11 /FS.7.1.2) to Rest of the world financing schemes (HF.4.2. Voluntary RoW schemes).

(4) Foreign support going to domestic NGO that raises funds both from domestic and foreign institutions and then supports (transfers money to) other NGOs acting as financing schemes. The NPISHs financing scheme receives its revenues from domestic NGO and it is likely that the origin of this revenues cannot be distinguished between foreign and domestic. In this case, the revenue is accounted as FS.6.3

(5) ODA statistics report commitments made by donor countries to international organisations (that may not be used in the given accounting period). Such data are not included in SHA, as the main issue of SHA – from the point of view of foreign aid - is to reports the revenue-raising by financing schemes.

(6) Debt relief is treated as a specific kind of Budget support

CHAPTER 7 ANALYSING HEALTH FINANCING FROM THE PERSPECTIVE OF TYPES OF SCHEMES AND INSTITUTIONAL UNITS

This chapter provides two related methods for constructing NHAs and/or analysing in more detail some of the main health financing schemes or institutional units separately:

- a way to show the relationships between FS, HF and FA in the case of a particular financing scheme;

- sectoral accounts (expenses and revenues for individual types of financing schemes, as well as individual types of institutional units).

194. Health accountants can organize the NHA production process in a variety of ways. Countries may prepare NHAs without the approaches discussed in this chapter or may use some of them as additional tools to analyse the main health financing schemes or institutional units separately. The approach outlined in this chapter is one possible starting point in constructing NHAs.

195. Sectoral (or T-accounts) can provide information on revenue-raising and health spending from the perspective of individual categories of financing schemes and institutional units of the health sector. This approach can be particularly useful, for example, not only in the compilation of data but also to analyse the role of particular financing arrangements in the health sector. Furthermore, the use of such accounts can be particularly useful in reconciling and checking data consistency. For each financing scheme, sectoral accounts provide information from the perspective of uses (spending) and resources (revenues).

196. The relationship between revenues (FS), schemes (HF) and agents (FA) is discussed for the main categories (or sub-categories) of financing schemes, apart from households' out-of-pocket payments. The clarification of these relationships is not only a starting point for preparing sectoral accounts, but useful information for the mapping between SHA 1.0 and SHA 2011, as well as for preparing the data on expenditure and revenues by financing scheme and financing agent. This chapter presents sectoral accounts for four cases (HF.1.1.1, FA.1.1, HF.1.2.1 and FA.1.1.4).

Relationship between FS, HF and FA

197. SHA 2011 provides the basic classifications used to account the flows in the health system. In addition, a clear picture of the FS–HF–FA relationships separately prepared for each financing scheme can contribute to a deeper analysis of health financing schemes; and also to the preparation of more reliable SHA data.

198. For each financing scheme, separate tables show the revenues and financing agents; they show the relationships between FS and HF and HF and FA. (The main FS and FA categories are shaded in the table.) In addition, columns may be added to record the value of revenues and expenditure managed by each financing agent under the rules of the financing schemes examined.

199. The alternative approach is to start with a list of financing agents (FA) and for each of these, the schemes (HF) and revenues (FS) can be presented. As a next step, the FS, HF and FA relationship can be specified.

200. The FS-HF-FA tables show (on their left side) the types of revenues the health financing schemes can raise; and (on their right side) the institutional units that can serve as a financing agent for the given financing scheme. The tables do not intend to show the direct relationship between FS and FA.

201. The Guidelines do not provide FS-HF-FA tables for all categories of financing schemes. However, based on these examples, health accountants can prepare similar tables for the other categories or country specific sub-categories of financing schemes. For example, if a country has compulsory long-term-care insurance as a sub-category of HF.1.2.1, it may be useful to identify its revenues and financing agents.

202. These tables can serve as working tables to compile data on revenues and expenses by financing scheme (or agent). They can also improve the information stored in the database if needed (e.g. if some inconsistencies are shown in the estimation parts used or in the actual data).

203. The right-hand side of the table can be further developed into a FAxHC (or FAxHP) matrix, to show e.g. expenditure by function - administered by each FA under the rules of the financing scheme. Then, the HFxFAxHC (HFxFAxHP) table can be assembled from the tables of individual financing schemes.

Relationships between FS, HF and FA: Governmental (health financing) schemes (HF.1.1)

204. Table 7.1 provides a description of Central governmental schemes. The basic method for revenue-raising is via transfers from government domestic revenues. Foreign revenues can also play an important role, particularly in lower income countries. Some specific government programmes (e.g., prevention programme targeting children living in poor areas) can also raise funds from corporations and individuals.

Table 7.1 Central governmental schemes: types of revenues and relevant financing agents

Revenues of HF.1.1.1				**Financing agents administering HF.1.1.1**		
FS.1	**Transfers from government domestic revenue (allocated for health purposes)**	NCU	**HF.1.1.1. Central governmental schemes**	FA.1.1.1	Ministry of Health	NCU
FS.1.1	Internal transfers and grants			FA.1.1.2	Other ministries and public units (belonging to central government)	
FS.2	Transfers distributed by government from foreign origin			FA.1.1.3	National Health Service Agency	
FS.6	Other domestic revenues n.e.c.			FA.1.2	State/regional/local government	
FS.6.1	Other revenues from households n.e.c.			FA.1.9	Other general government units	
FS.6.2	Other revenues from corporations n.e.c.			FA.3.1	Health management and provider corporations	
FS.6.3	Other revenues from NPISH n.e.c.			FA.4	Non-profit institutions serving households (NPISHs	
FS.7	Direct foreign transfers					
FS.7.1	Direct foreign financial transfers					
FS.7.1.1	Direct bilateral financial transfers					
FS.7.1.2	Direct multilateral financial transfers					
FS.7.2	Direct foreign aid in kind					
FS.7.2.1	Direct foreign aid in goods					
FS.7.2.1.1	Direct bilateral aid in goods					
FS.7.2.1.2	Direct multilateral aid in goods					
FS.7.2.2	Direct foreign aid in kind: services (including TA)					

205. The typical financing agents for HF.1.1.1 are government units. Countries may want to record the spending by different government units separately. Furthermore, government may contract

NPISHs or management corporations to implement specific programmes such as a public health campaign. It is important to make a distinction between NPISHs or corporations acting as financing agents from those providing health care (and thus accounted as providers).

206. Accountants can specify the relevant revenues and financing agents (including country-specific sub-categories). The tables contain columns (NCU) for the scheme revenues and HF.1.1.1-specific spending of the financing agents concerned.

207. Such a qualitative description of the FS-HF-FA relationships can serve as a basis for producing sectoral accounts (Table 7.2). The left-hand side presents the sectoral account of the central governmental schemes (HF.1.1.1). As data can be obtained from the financing agents administering the central governmental schemes, it is necessary to examine all the financing agents involved in managing a central governmental scheme. The right-hand side only displays two of the financing agents: Ministry of Health and NPISHs. These background tables only contain the HF.1.1.1-related revenues and expenses of the given financing agent. After having compiled such background tables for all relevant financing agents, the data of the sectoral accounts of HF.1.1.1 can be calculated:

- The revenues of HF.1.1.1 equal the sum of HF.1.1.1-related revenues of all the financing agents involved in administering central governmental schemes. The relevant (HF.1.1.1-related) administrative costs of financing agents only involved in revenue collection should also be added (as a component of HC.7xHF.1.1.1).
- The expenses of HF.1.1.1 equal the sum of HF.1.1.1-related expenses of all the financing agents involved in administering central governmental schemes.

208. Chapter 4 has already discussed that spending by governmental financing schemes is only one component of health spending by the government (Ministry of Health) as an institutional unit.

209. The expense categories of the sectoral accounts can be the HP or HC categories or economic types of expenses, such as compensation of employees, use of goods and services, etc. (See Table D.1.2. in Annex D in the SHA 2011 Manual).

Table 7.2 Sectoral accounts of HF.1.1.1 central governmental schemes

Revenues and expenses of HF.1.1.1 Central governmental schemes (Mln NCU)						Background tables: *HF.1.1.1. related Revenues and expenses of Ministry of Health (FA.1.1.1)*				*HF.1.1.1. related Revenues and expenses of NPISHs (FA.4)*			
	Expenses			**Revenues**			***Expenses***		***Revenues***		***Expenses***		***Revenues***
			FS.1	**Transfers from government domestic revenue (allocated to health purposes)**				***FS.1***				***FS.1***	
HP.1	**Hospitals**		FS.1.1	Internal transfers and grants		***HP.1***		*FS.1.1*		***HP.1***		*FS.1.1*	
HP.2	**Residential long-term care facilities**		FS.2	Transfers distributed by Government from foreign origin		***HP.2***		*FS.2*		***HP.2***		*FS.2*	
HP.3	**Providers of ambulatory health care**		FS.6	Other domestic revenues n.e.c.		***HP.3***		*FS.6*		***HP.3***		*FS.6*	
HP.4	**Providers of ancillary services**		FS.6.1	Other revenues from households n.e.c.		***HP.4***		*FS.6.1*		***HP.4***		*FS.6.1*	
HP.5	**Retailers and other providers of medical goods**		FS.6.2	Other revenues from corporations n.e.c.		***HP.5***		*FS.6.2*		***HP.5***		*FS.6.2*	
HP.6	**Providers of preventive care**		FS.6.3	Other revenues from NPISH n.e.c.		***HP.6***		*FS.6.3*		***HP.6***		*FS.6.3*	
HP.7	**Providers of health care system administration and financing**		FS.7	Direct Foreign transfers		***HP.7***		*FS.7*		***HP.7***		*FS.7*	
HP.7.1	Government health administration agencies		FS.7.1	Direct Foreign financial transfers		*HP.7.1*		*FS.7.1*		*HP.7.1*		*FS.7.1*	
HP.7.2	Social health insurance agencies		FS.7.1.1	Direct Bilateral financial transfers		*HP.7.2*		*FS.7.1.1*		*HP.7.2*		*FS.7.1.1*	
HP.7.3	Private health insurance administration agencies		FS.7.1.2	Direct Multilateral financial transfers		*HP.7.3*		*FS.7.1.2*		*HP.7.3*		*FS.7.1.2*	
HP.7.9	Other administration agencies		FS.7.2	Direct Foreign aid in kind		*HP.7.9*		*FS.7.2*		*HP.7.9*		*FS.7.2*	
Net/Gross operating balance													

The health-specific sectoral account of central government (FA.1.1)

210. Table 7.3 presents the sectoral account for all the health-specific revenues and expenses of the government as an institutional unit. This concerns all components of government involvement in health care financing, including its role as financing agent and provider of financial resources. Furthermore, it includes government as a unit producing health care. For example, under its role as a provider of financial resources, the government may provide grants to an NPISH which acts as a financing scheme or pay social contributions on behalf of children or elderly persons to compulsory social insurance schemes. The sectoral account of the government (as an institutional unit) may include social insurance contributions among the revenues and social security benefits among the expenses, as social insurance schemes can be managed by a government unit. Sectoral accounts also provide a tool for analysing the role of foreign revenues in financing health care.

Table 7.3 Sectoral account of FA.1.1 Central government

	Expenses	NCU		Revenues	NCU
HC.1 to HC.8	**Expenditure by governmental financing schemes**		**FS.1**	**Government domestic revenue**	
HCR.1, HCR.2	Spending on government health-related functions		**FS.2**	**Transfers distributed by governments from foreign origin**	
HC.1 to HC.8	**Expenditure by SHI scheme managed by a government unit: National Health Insurance Agency (FA.1.1.4)**		**FS.3**	**Social insurance contributions**	
	Investment in human and physical capital and R&D		**FS.5**	Voluntary prepayment	
			FS.6	**Other domestic revenues n.e.c.**	
	Internal transfers and grants		**FS.7**	**Direct foreign transfers**	
	Transfers by the government on behalf of specific groups		FS.7.1	Direct foreign financial transfers	
	Subsidies		FS.7.2	Direct foreign aid in kind	
	Other transfers from government domestic revenue		FS.7.3	Other direct foreign transfers (n.e.c.)	
	Transactions made as an intermediary institution				
	Non-health spending by government units acting as health financing agents				
Net/Gross operating balance					

Relationships between FS, HF and FA: Social health insurance schemes (HF.1.2.1)

211. Social health insurance is a financing arrangement ensuring access to health care based on a payment of a non-risk related contribution by or on behalf of an eligible person. The social health insurance scheme is established by a specific public law, defining the eligibility, benefit package and rules for contribution payment.

212. Table 7.4 indicates the types of revenues SHI schemes can raise and the types of agents that can be involved in their administration. The table contains columns (NCU) for the value of revenues of HF.1.2.1 schemes and the value of spending managed by the given financing agents under the rules of SHI schemes. (On the right-hand side, data on HC or HP can be added in the form of a FAxHC (FAxHP) matrix, which can then be aggregated into an HF.1.2.1xHC vector.)

213. Countries can select the relevant categories to prepare the sectoral accounts. The process is similar to the one described for HF.1.1.1.

Table 7.4 Social health insurance schemes (HF.1.2.1): types of revenues and relevant financing agents

Revenues of HF.1.2.1		**NCU**		**Financing agents administering HF.1.2.1**		**NCU**
FS.1	**Transfers from government domestic revenue (allocated for health purposes)**		**HF.1.2.1 Social health insurance schemes**	FA.1.1.4	National Health Insurance Agency	
FS.1.1	Internal transfers and grants			FA.1.3.1	Social health insurance agency	
FS 1.2	Transfers by government on behalf of specific groups			FA.1.3.2	Other social security agency	
FS.1.3	Subsidies			FA.2.1	Commercial insurance companies	
FS 1.2	Transfers by government on behalf of specific groups			FA.2.2	Mutual and other non-profit insurance organisations	
FS.3	**Social insurance contributions**			FA.3.1	Health management and provider corporations	
FS.3.1	Social insurance contributions from employees			FA.3.2	Corporations (other than providers of health services)	
FS.3.2	Social insurance contributions from employers			FA.4	Non-profit Institutions serving households (NPISHs)	
FS.3.3	Social insurance contributions from self-employed			FA.6	Rest of the World	
FS.3.4	Other social insurance contributions					
FS.7.1	Direct foreign financial transfers					

Specific issues

Foreign transfers and agents

214. An individual may be resident in one country and work for a company resident in another. It may be possible for the individual to be contracted with the National Social Health Insurance Agency in the country of residence. His/her contribution may be paid by the foreign employer (FS.7.1).

215. The Social Health Insurance Agency (SHIA) in a country may have an agreement with the social insurance agency of another country such that the latter reimburses its domestic health care providers directly for health care provided for persons insured in the former. In this case, the two insurance agencies settle the balance at the end of the year. This is an import of services from foreign providers under the health insurance scheme with the help of a foreign health financing agent (FA.6).

Types of government transfers

216. Social insurance contributions are usually the main type of revenue for social insurance. However, transfers from government domestic revenue (FS.1) can play a substantial role, typically in the following cases:

- The government may pay the insurance contribution on behalf of specific groups of the population (e.g., the children, the elderly, the unemployed, etc.). This is accounted as: FS 1.2. Transfers by government on behalf of specific groups
- The government may cover the deficit of a social insurance scheme from the state budget. The way it is accounted depends on the different institutional arrangements of the social health insurance scheme.
  - If the institution administering the SHI scheme is a government unit (FA.1), the transfer covering the debt is accounted as FS.1.1. Internal transfers and grants.

- If the institution administering the SHI scheme is an insurance corporation (FA.2) or other corporation (FA.3) (including public corporations), the transfer covering the debt is accounted as FS.1.3 Subsidies.

217. In a country with complex SHI schemes (with several types of revenues and financing agents involved), it may be useful to prepare a sectoral account of SHI schemes, showing the complex relationships between FS, HF, FA and HP(HC). Table 7.5 provides an example.

The sectoral account of the National Health Insurance Agency (FA.1.1.4)

218. It may also be useful to prepare sectoral accounts from an institutional point of view. Table 7.6 provides an example. Let's suppose that both the National Health Insurance Agency and insurance companies can offer voluntary health insurances. Therefore, the sectoral account of the National Health Insurance Agency shows both health-specific activities. Moreover, the sectoral account shows the non-health related activities of the NHIA also. (For example, it may also administer family allowances).

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Table 7.5 Sectoral accounts of Social Health Insurance schemes (HF.1.2.1)

Revenues and expenses of HF.1.2.1 Social Health Insurance schemes (Mln NCU)						Background tables: HF.1.2.1. related Revenues and expenses of National Health Insurance agency (FA.1.1.4)				Background tables: HF.1.2.1. related Revenues and expenses of Insurance Corporations (FA.2)			
	Expenses			**Revenues**			***Expenses***		***Revenues***		***Expenses***		***Revenues***
			FS.1	**Transfers from government domestic revenue (allocated to health purposes)**				**FS.1**				**FS.1**	
HP.1	**Hospitals**		FS.1.1	Internal transfers and grants		***HP.1***		FS.1.1		***HP.1***		FS.1.1	
HP.2	**Residential long-term care facilities**		FS.1.2	Transfers by Government on behalf of specific groups		***HP.2***		FS.1.2		***HP.2***		FS.1.2	
HP.3	**Providers of ambulatory health care**		FS.1.3	Subsidies		***HP.3***		FS.1.3		***HP.3***		FS.1.3	
HP.4	**Providers of ancillary services**		**FS.3**	**Social insurance contributions**		***HP.4***		**FS.3**		***HP.4***		**FS.3**	
HP.5	**Retailers and other providers of medical goods**		FS.3.1	Social insurance contributions from employees		***HP.5***		FS.3.1		***HP.5***		FS.3.1	
HP.6	**Providers of preventive care**		FS.3.2	Social insurance contributions from employers		***HP.6***		FS.3.2		***HP.6***		FS.3.2	
HP.7	**Providers of health care system administration and financing**		FS.3.3	Social insurance contributions from self-employed		***HP.7***		FS.3.3		***HP.7***		FS.3.3	
HP.7.1	Government health administration agencies		FS.3.4	Other social insurance contributions		*HP.7.1*		FS.3.4		*HP.7.1*		FS.3.4	
HP.7.2	Social health insurance agencies		FS.6.1	Other revenues from households n.e.c.		*HP.7.2*		FS.6.1		*HP.7.2*		FS.6.1	
HP.7.3	Private health insurance administration agencies		FS.6.2	Other revenues from corporations n.e.c.		*HP.7.3*		FS.6.2		*HP.7.3*		FS.6.2	
HP.7.9	Other administration agencies		FS.6.3	Other revenues from NPISH n.e.c.		*HP.7.9*		FS.6.3		*HP.7.9*		FS.6.3	
			FS.7.1	Direct Foreign financial transfers				FS.7.1				FS.7.1	
Net/Gross operating balance													

Table 7.6 Sectoral accounts of the National Health Insurance Agency (FA.1.1.4)

Revenues and expenses of FA.1.1.4 National Health Insurance agency (Mln NCU)						Background tables											
						HF.1.2.1. related revenues and expenses of National Health Insurance agency (FA.1.1.4)				*HF.2.1. related revenues and expenses of National Health Insurance agency (FA.1.1.4)*				*Other revenues and expenses of National Health Insurance agency (FA.1.1.4)*			
	Expenses			**Revenues**			***Expenses***		***Revenues***		***Expenses***		***Revenues***		***Expenses***		***Revenues***
HC.1 to HC.6	Services and goods provided under SHI		**FS.1**	**Transfers from government domestic revenue (allocated to health purposes)**		*HC.1*		**FS.1**		*HC.1*		**FS.1**				**FS.1**	
HC.1 to HC.6	Services and goods provided under VHI		FS.1.1	Internal transfers and grants		*HC.2*		FS.1.1		*HC.2*		FS.1.1				FS.1.1	
HC.7	Administration costs related to SHI		**FS.3**	**Social insurance contributions**		*HC.3*		**FS.3**		*HC.3*		**FS.3**				**FS.3**	
HC.7	Administration costs related to VHI		FS.3.1	Social insurance contributions from employees		*HC.4*		FS.3.1		*HC.4*		FS.3.1				FS.3.1	
			FS.3.2	Social insurance contributions from employers		*HC.5*		FS.3.2		*HC.5*		FS.3.2				FS.3.2	
	Payments for benefits under other domestic social		FS.3.3	Social insurance contributions from self-employed		*HC.6*		FS.3.3		*HC.6*		FS.3.3				FS.3.3	
	Payments to providers under bilateral agreements		FS.6.1	Other revenues from households n.e.c.		*HC.7*		FS.6.1		*HC.7*		FS.6.1				FS.6.1	
	Other operating costs of NHIA		FS.6.2	Other revenues from corporations n.e.c.		*HC.8*		FS.6.2		*HC.8*		FS.6.2				FS.6.2	
	Investment costs		FS.6.3	Other revenues from NPISH n.e.c.				FS.6.3				FS.6.3				FS.6.3	
			FS.7.1	Direct Foreign financial transfers				FS.7.1				FS.7.1				FS.7.1	
Net/Gross operating balance																	

Relationships between FS, HF and FA: Voluntary health insurance (VHI) schemes

219. Voluntary health insurance (VHI) schemes have the following characteristics:

- Mode of participation: voluntary, at the discretion of an individual or a firm;
- Benefit entitlement: contributory: based upon the purchase of the voluntary health insurance policy (usually on the basis of a contract);
- Basic method for fund-raising: usually non-income-related premiums (often directly or indirectly risk-related,); may be directly or indirectly subsidised by the government (e.g. through tax credits);

220. When preparing NHAs the following decisions should be made:

- how many different types of insurance companies are to be separated in the data collection
- whether to include VHI at two-digit level (i.e., only HF.2.1) or to distinguish VHI sub-categories.
- whether to create further subcategories
- whether to prepare sectoral accounts for VHI scheme
- whether to prepare sectoral accounts for private health insurance companies (including each scheme operated by them)

221. For example, a country may have only 'Other complementary/supplementary insurance' (HF.2.1.2.2). However, it is important to identify the different types, such as group insurance with non-risk related premium and commercial individual policies with risk-related premiums. In which case, it is worthwhile to produce, is the following table for each subcategory:

Table 7.7 Voluntary health insurance schemes: types of revenues and relevant financing agents

	Revenues of VHI schemes	NCU			Financing agents administering VHI schemes	NCU
FS.1	**Transfers from government domestic revenue (allocated to health purposes)**		**HF.2.1 Voluntary health insurance schemes**	FA.1.1.4	National Health Insurance Agency	
FS 1.2	Transfers by the government on behalf of specific groups			FA.1.3.1	Social health insurance agency	
FS.1.3	Subsidies			FA.1.3.2	Other social security agency	
FS.5	**Voluntary prepayment**			FA.1.9	All other general government units	
FS.5.1	Voluntary prepayment from individuals/households			FA.2.1	Commercial insurance companies	
FS.5.2	Voluntary prepayment from employers			FA.2.2	Mutual and other non-profit insurance organisations	
FS.5.3	Other voluntary prepaid revenues			FA.3.1	Health management and provider corporations	
FS.6.2	Other revenues from corporations n.e.c.			FA.3.2	Corporations (other than providers of health services)	
FS.6.3	Other revenues from NPISH n.e.c					
FS.7.1	Direct foreign financial transfers					

222. The table contains columns (NCU) for the revenues of VHI schemes and the spending managed by the given financing agents under the rules of VHI schemes. (On the right-hand side, data on HC (or HP) can be added in the form of a FAxHC (FAxHP) matrix and then be aggregated into an HF.2.1.x HC vector.)

223. If VHI schemes play an important role in a country's health financing, it may be useful to prepare sectoral accounts for both the VHI schemes and commercial insurance companies (FA.2.1).

Specific accounting issues

224. Private insurance corporations may use interest revenue for activities related to the provision of health insurance. These receipts have to be included as revenues for health care only when they are used to fund health services (including the administration of health insurance). The recording of revenues from interest should be part of FS.6.2

Relationships between FS, HF and FA: Non-profit Institutions financing schemes (HF.2.2)

225. NPISH financing arrangements or financing programmes consist of a "quasi set" of rules that define the mode of participation, entitlement and methods of fund-raising, and hence they can be treated as categories of financing schemes.

NPISH financing schemes have the following characteristics:

- Mode of participation: voluntary;
- Benefit entitlement: non-contributory, discretionary;
- Basic method for fund-raising: donations from the general public, governments (budget of national government or foreign aid) or corporations;

226. The first step is to distinguish the major roles non-profit organizations play in the health system. It always requires a qualitative analysis of an NGO's activity to decide whether the given activity can be regarded as the operation of a financing scheme. A few examples are given for the different functions of NPISHs.

- *Provider of revenues*. An NPISH may provide – besides their non-health activities – resources for other NPISHs that carry out the financing of special health programmes. The NPISH (1) in question does not have a direct relationship with providers of care. In this case NPISH (1) is a provider of resources and the programme of the NPISH (2) is the financing scheme.
- *Financing schemes*. A non-profit institution may create a special fund, usually through donations, to finance special types of health services. For example, these could include operating special facilities for the homeless or providing care for households affected by natural disasters or war. Donations may be provided in cash or in kind from the general public, corporations or governments. During the implementation the NPISH may pay for its own staff and also for health care providers and other entities. (For example a charity organisation may pay for a special operation for a child abroad that is not available in the home country.) In these cases the NPISH programme is a financing scheme.
- *Financing agents* (e.g., for governmental financing schemes).
- *Provider*. The "non-profit" institution may be the legal form of providers receiving payment, for example from the social health insurance scheme as compensation for the services it provides. In this case the non-profit organisation is a provider, and the social health insurance is the financing scheme
- 227. The typical financing agent for HF.2.2 is FA.4. NPISHs. However, there may be specific cases when a Non-profit foundation plans and finances a health program (e.g., vaccination of children), but it contracts a corporation (e.g., FA.3.1) for the concrete implementation. The health management corporation pays the health providers involved in the program.

Table 7.8 NPISH financing schemes: types of their revenues and financing agents

Revenues of HF.2.2		NCU		Financing agents managing HF.2.2		NCU
FS.1	Transfers from government domestic revenue (allocated to health purposes)		**HF.2.2 Non-profit Institutions financing schemes**	FA.3.1	Health management and provider corporations	
FS.1.4	Other transfers from government domestic revenue			FA.4	Non-profit Institutions Serving Households (NPISHs)	
FS.6	Other domestic revenues n.e.c.					
FS.6.1	Other revenues from households n.e.c.					
FS.6.2	Other revenues from corporations n.e.c.					
FS.6.3	Other revenues from NPISH n.e.c.					
FS.7	Direct foreign transfers					

228. Similar to other financing schemes, the table contains columns (NCU) for the value of revenues of HF.2.2 and the value of spending managed by the relevant financing agents. (On the right-hand side, data on HC or HP can be added in the form of a FAxHC (FAxHP) matrix, with an aggregate HF.2.2 x HC vector.)

Relationships between FS, HF and FA: Enterprise financing schemes (HF.2.3)

229. The characteristics of Enterprise financing schemes are:

- Mode of participation: mostly voluntary choice of particular enterprise/corporation[39], usually with coverage based on employment at such a firm (e.g. compulsory occupational health care);
- Benefit entitlement: non-contributory, discretionary with regard to the type of services, though may sometimes be specified by law
- Method for fund-raising: voluntary choice of the firm to use its revenues for this purpose

HF.2.3. has two sub-categories of different characteristics from the point of view of the beneficiaries:

- under HF.2.3.1, the beneficiaries are the employee of the given enterprise
- under HF.2.3.2, the beneficiaries are some of the patients treated in the given hospital

HF.2.3.1. Enterprise (except Health care providers) financing schemes

230. This category primarily includes arrangements where enterprises provide or finance directly health services for their employees (such as occupational health services) without the involvement of an insurance-type scheme. Therefore, this excludes employer-based insurance schemes.

231. The table contains columns (NCU) for the value of revenues of HF.2.3.1 schemes and the value of spending managed by the relevant financing agents. (On the right-hand side, data on HC or HP can be added in the form of a FAxHC (FAxHP) matrix, with an aggregate HF.2.3.1x HC vector.)

[39] Unless there is a state regulation ordering certain types of employers to offer their personnel a health insurance or health service. From the employee's point of view, participation could be mandatory (part of the contract) or voluntary.

Table 7.9 HF.2.3.1 Enterprise (except health care providers) financing schemes: types of revenues and financing agents

Revenues of HF.2.3.1		NCU		Financing agents managing HF.2.3.1		NCU
FS.1.3	Subsidies		**HF.2.3.1 Enterprise (except Health care providers) financing schemes**	FA.3.1	Health management and provider corporations	
FS.6.1	Other revenues from households n.e.c.			FA.3.2	Corporations (other than providers of health services)	
FS.6.2	**Other revenues from corporations n.e.c.**			FA.4	Non-profit Institutions Serving Households (NPISHs)	

HF.2.3.2. Health care providers financing schemes

232. Provider institutions may receive donations from corporations, households and NPISHs. They can use these resources in different ways:

- as additional funds for health care services for patients,
- as funds for the health services for the personnel (occupational health), and
- in order to offer health insurance for employees and dependents.

233. The type of financing agent depends on the institutional form of the given provider. A special example of this occurs when health care providers (e.g. hospitals) earn money (interest) by keeping their funds in banks. The health care providers may spend this extra income on providing health care. In this case, the financing scheme is HF.2.3.2 "Health care providers financing scheme" (which is a sub-category of "Enterprise financing schemes"); the revenue category is FS.6.2 "Other revenues from corporations".[40]

Table 7.10. HF.2.3.2. Health care providers financing schemes: types of revenues and financing agents

Revenues of HF.2.3.2		NCU		Financing agents administering HF.2.3.2		NCU
FS.6	**Other domestic revenues n.e.c.**		**HF.2.3.2 Health care providers financing schemes**	FA.1.9	All other general government unit	
FS.6.1	Other revenues from households n.e.c.			FA.3.1	Health management and provider corporations	
FS.6.2	Other revenues from corporations n.e.c.					
FS.6.3	Other revenues from NPISH n.e.c.					
FS.7.1	**Direct foreign financial transfers**					

234. The table contains columns (NCU) for the value of revenues of HF.2.3.2 schemes and the value of spending managed by the relevant financing agents. (On the right-hand side, data on HC or HP can be added in the form of a FAxHC (FAxHP) matrix, with an aggregate of the HF.2.3.2 x HC vector.)

[40] As the health care providers generate the extra resource – from the interest – and voluntarily decide to use it on patient care. In fact, the "transfer" is an internal transfer within the health care providers.

ANNEX 1 PREPARING SHA 2011 HEALTH CARE FINANCING TABLES

This annex briefly describes the preparation and use of HCxHF, HPxHF and HFxFS tables under SHA 2011. It should be read in conjunction with Chapters 14 and 15 of the SHA 2011 Manual.

Health accounts tables related to health financing

235. The SHA 2011 Manual (Chapter 15) describes the following two-dimensional tables linked to health care financing, and the main information they provide:

- Health expenditure by type of financing scheme and by function (HCxHF)
- Health expenditure by financing scheme and by type of provider (HPxHF)
- Revenues of the financing schemes by types of revenues (HFxFS)
- Health expenditure by financing scheme and financing agent (HFxFA)

236. Apart from the HFxFA table, these are the same financing tables as under SHA 1.0 and PG. However, since the concepts and categories of the HF and FS classifications have been revised compared to SHA 1.0, the information provided by the tables has also changed. Although current expenditure by health care function and provider table (HC x HP) does not explicitly include a dimension of financing, it can also be regarded as relevant to health financing. In fact, the HC x HP table is an aggregate of the individual HC x HP tables of each financing scheme that provide comprehensive information about the allocation of financial resources.

237. From the point of view of resource-flows in the health care system, these tables provide information about the mechanisms through which financing schemes raise their resources and how they then allocate those resources among health care functions and providers. For example, HCxHF might show what share of the resources of compulsory insurance schemes is spent on pharmaceuticals, inpatient care, outpatient care and prevention, etc. It also allows an analysis of how different services are financed, e.g., what share of inpatient care is available under compulsory insurance and what share of inpatient care is purchased through voluntary insurance or out-of-pocket. The HPxHF table shows who produces the health services and goods, and which financing scheme purchased them for the consumers.

238. The HFxFA table shows the institutional arrangements of health care financing. The table addresses the question of "who manages which payment scheme". The analysis of this table may be particularly useful where there are complex institutional arrangements, and during periods of reform involving changes in the health financing institutional structure.

239. Additionally, the three-dimensional tables detailed below can serve the following purposes:

- as intermediate working tables to produce HCxHF, HPxHF and HFxFS tables;
- to analyse the information gathered for completeness and consistency;
- as "output" tables in their own right, also for analytical purpose.

Expenditure on health care by financing schemes, providers and function (HFxHPxHC)

240. This table provides comprehensive information about the structure of final consumption of health care: What kind of services and goods are available to the population, from what providers and under what kind of financing arrangements?

Expenditure on health care by financing schemes, financing agents and providers (*HFxFAxHP)*

241. This table completes the information provided by the HPxHF table with information on the institutional structure of health financing not only at the scheme level, but also according to the main providers. The table shows the transactions between agents and providers under the particular schemes.

Expenditure on health care by financing schemes, financing agents and functions (HFxFAxHC)

242. This table completes the HCxHF table with information on the institutional structure of health financing, not only at the scheme level, but also according to the main areas (functions) of health care services. While HCxHF provides information on how a particular financing sub-system allocates its resources (e.g. what share of the resources of the compulsory insurance scheme is spent on pharmaceuticals, inpatient care, outpatient care and prevention, etc.), the HFxFAxHC table shows, in addition, via what institutional arrangements payment for services is made.

Revenues of financing schemes by types of revenues and financing agents (HFxFAxFS)

243. This table supplements the HFxFS table with information on "who collects and manages the revenues" of the particular financing schemes. The table focuses on the financing agents that purchase health care. In order to calculate the whole administrative costs of the financing schemes, the table also includes the agents involved only in the revenue-collection activities[41].

244. These three-dimensional tables can be useful tools for monitoring changes in the institutional setting of health financing such as comparing the transaction (administrative) costs of different structural arrangements of the same scheme (e.g., in the case of social insurance).

[41] As already noted, the terms "managing the scheme" includes revenue-collection, pooling and purchasing. Consequently, FAs includes institutional units that only collect revenues, but are not involved in purchasing.

ANNEX 2
SHA 2011 CLASSIFICATIONS AND RELATED TOOLS

Table A2.1 Classification of Health Care Financing Schemes (ICHA-HF)

HF.1	**Governmental schemes and compulsory contributory health financing schemes**
HF.1.1	**Governmental schemes**
HF.1.1.1	Central governmental schemes
HF.1.1.2	State/regional/local governmental schemes
HF.1.2	**Compulsory contributory health insurance schemes**
HF.1.2.1	Social health insurance schemes
HF.1.2.2	Compulsory private insurance schemes
HF.1.3	**Compulsory Medical Saving Accounts (CMSA)**
HF.2	**Voluntary health care payment schemes**
HF.2.1	**Voluntary health insurance schemes**
HF.2.1.1	Primary/substitutory health insurance schemes
HF.2.1.1.1	Employer-based insurance (other than enterprise schemes)
HF.2.1.1.2	Government-based voluntary insurance
HF.2.1.1.3	Other primary coverage schemes
HF.2.1.2	Complementary/supplementary insurance schemes
HF.2.1.2.1	Community-based insurance
HF.2.1.2.2	Other complementary/supplementary insurance
HF.2.2	**NPISHs financing schemes**
HF.2.2.1	NPISHs financing schemes (excluding HF.2.2.2)
HF.2.2.2	Resident foreign agencies schemes
HF.2.3	**Enterprises financing schemes**
HF.2.3.1	Enterprise (except health care providers) financing schemes
HF.2.3.2	Health care providers financing schemes
HF.3	**Household out-of-pocket payment**
HF.3.1	**Out-of-pocket excluding cost sharing**
HF.3.2	**Cost sharing with third-party payers**
HF.3.2.1	Cost sharing with governmental schemes and compulsory contributory health insurance schemes
HF.3.2.2	Cost sharing with voluntary insurance schemes
HF.4	**Rest of the world financing schemes (non resident)**
HF.4.1	**Compulsory schemes (non-resident)**
HF.4.1.1	Compulsory health insurance schemes (non-resident)
HF.4.1.2	Other compulsory schemes (non-resident)
HF.4.2	**Voluntary schemes (non-resident)**
HF.4.2.1	Voluntary health insurance schemes (non-resident)
HF.4.2.2	Other schemes (non-resident)
HF.4.2.2.1	Philanthropy/international NGO schemes
HF.4.2.2.2	Foreign development agency schemes
HF.4.2.2.3	Schemes of Enclaves (e.g., international organisations or embassies)
Memorandum items	
Financing agents managing the financing schemes	
HF.RI.1.1	Government
HF.RI.1.2	Corporations
HF.RI.1.3	Households
HF.RI.1.4	NPISHs
HF.RI.1.5	Rest of the World
Financing schemes and the related cost sharing together	
HF.RI.2	Governmental schemes and compulsory contributory health insurance schemes together with cost sharing (HF.1 + HF.3.2.1)
HF.RI.3	Voluntary health insurance schemes together with cost sharing (HF.2+HF.3.2.2)

Table A2.2 Classification of Financing Agents (ICHA-FA)

FA.1.		**General Government**
FA.1.1		Central government
	FA.1.1.1	Ministry of Health
	FA.1.1.2	Other ministries and public units (belonging to central government)
	FA.1.1.3	National Health Service Agency
	FA.1.1.4	National Health Insurance Agency
FA.1.2		State/Regional/Local government
FA.1.3		Social security agency
	FA.1.3.1	Social health insurance agency
	FA.1.3.2	Other social security agency
FA.1.9		All other general government units
FA.2		**Insurance corporations**
FA.2.1		Commercial insurance companies
FA.2.2		Mutual and other non-profit insurance organisations
FA.3		**Corporations (other than insurance corporations)**
FA.3.1		Health management and provider corporations
FA.3.2		Corporations (other than providers of health services)
FA.4		**Non-profit Institutions serving households (NPISHs)**
FA.5		**Households**
FA.6		**Rest of the World**
FA.6.1		International organisations
FA.6.2		Foreign governments
FA.6.3		Other foreign entities

Table A2.3 Classification of Revenues of Health care Financing Schemes

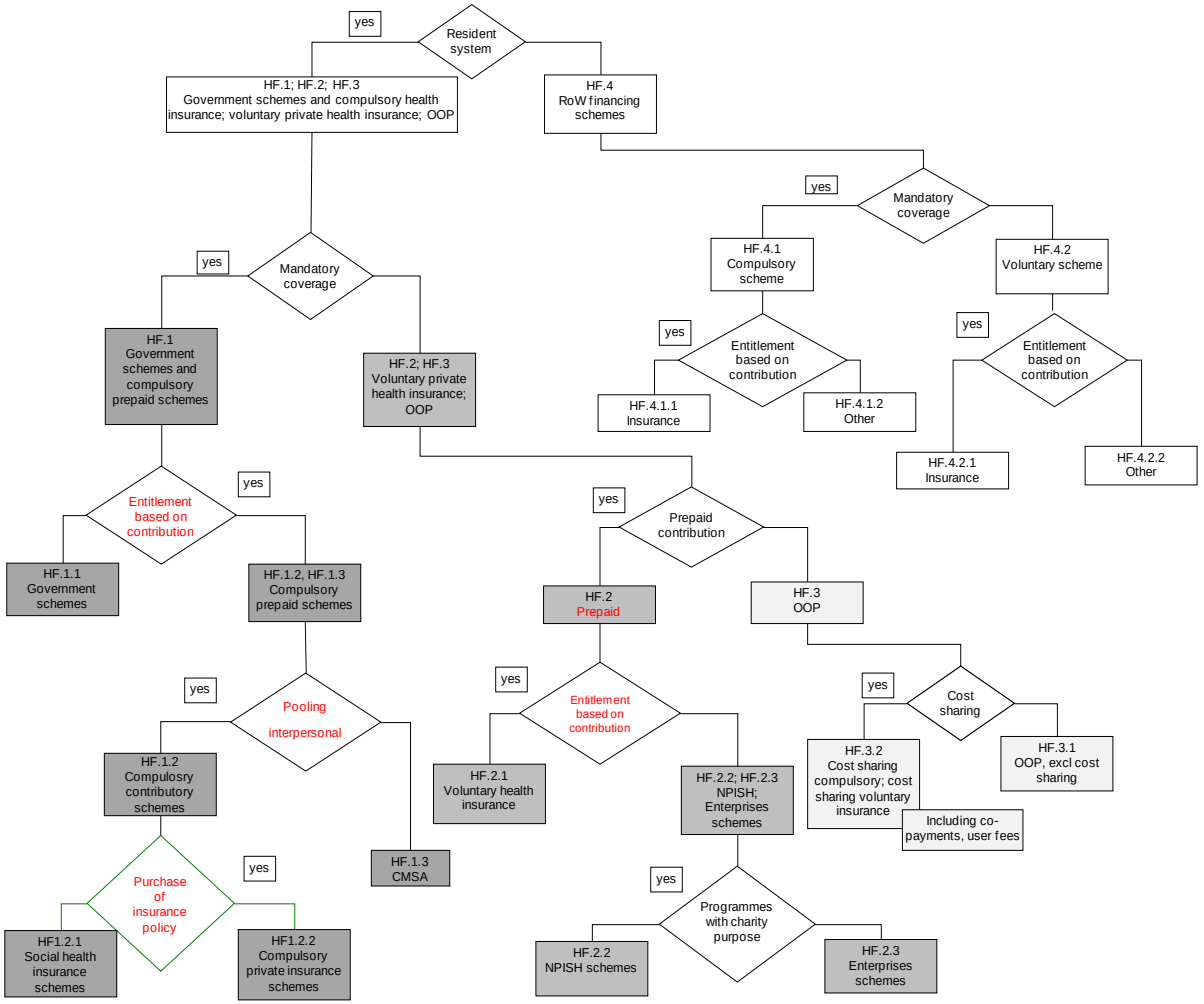
FS.1	**Transfers from government domestic revenue (allocated for health purposes)**
FS.1.1	Internal transfers and grants
FS 1.2	Transfers by government on behalf of specific groups
FS.1.3	Subsidies
FS.1.4	Other transfers from government domestic revenue
FS.2	**Transfers distributed by government from foreign origin**
FS.3	**Social insurance contributions**
FS.3.1	Social insurance contributions from employees
FS.3.2	Social insurance contributions from employers
FS.3.3	Social insurance contributions from self-employed
FS.3.4	Other social insurance contributions
FS.4	**Compulsory prepayment (other than FS.3)**
FS.4.1	Compulsory prepayment from individuals/households
FS.4.2	Compulsory prepayment from employers
FS.4.3	Other compulsory prepaid revenues
FS.5	**Voluntary prepayment**
FS.5.1	Voluntary prepayment from individuals/households
FS.5.2	Voluntary prepayment from employers
FS.5.3	Other voluntary prepaid revenues
FS.6	**Other domestic revenues n.e.c.**
FS.6.1	Other revenues from households n.e.c.
FS.6.2	Other revenues from corporations n.e.c.
FS.6.3	Other revenues from NPISH n.e.c.
FS.7	**Direct foreign transfers**
FS.7.1	**Direct foreign financial transfers**
FS.7.1.1	Direct bilateral financial transfers
FS.7.1.2	Direct multilateral financial transfers
FS.7.1.3	Other direct foreign financial transfers
FS.7.2	**Direct foreign aid in kind**
FS.7.2.1	Direct foreign aid in goods
FS.7.2.1.1	Direct bilateral aid in goods
FS.7.2.1.2	Direct multilateral aid in goods
FS.7.2.1.3	Other direct foreign aid in goods
FS.7.2.2	Direct foreign aid in kind: services (including TA)
FS.7.3	Other direct foreign transfers (n.e.c.)
Memorandum items	
Reporting items	
FS.RI.1	Institutional units providing revenues to financing schemes
FS.RI.1.1	Government
FS.RI.1.2	Corporations
FS.RI.1.3	Households
FS.RI.1.4	NPISH
FS.RI.1.5	Rest of the World
FS.RI.2	Total foreign revenues (FS.2 +FS.7)
FS Related Items	
FSR.1	Loans
FSR.1.1	Loans taken by government
FSR.1.2	Loans taken by private organisations
FSR.2	Aid in kind at donor value

Table A2.4 Main criteria of health financing schemes

	Mode of participation	Benefit entitlement	Basic method for fund-raising	Pooling
HF.1.1. Governmental schemes	Automatic: for all citizens/residents or a specific group of the population (e.g., the poor) defined by law/government regulation	Non-contributory: typically universal or available for a specific population group or disease category defined by law (e.g. TB, HIV, oncology)	Compulsory: budget revenues (primarily taxes)	National, sub-national, or program-level
HF.1.2.1 Social health insurance	Mandatory: for all citizens/residents or a specific group of the population defined by law/government regulation. In some cases, however, the enrolment requires actions to be made by the eligible persons.	Contributory: based on payment by or on behalf of the insured person	Compulsory: Non-risk related health insurance contribution. Insurance contributions may be paid by the government (from state budget) on behalf of some non-contributing groups of the population, and the government may also provide general subsidies to the scheme.	National, sub-national, or by scheme; with multiple funds, extent of pooling will depend on risk-equalization mechanisms across schemes.
HF.1.2.2 Compulsory private insurance	Mandatory: for all citizens/residents or a specific group of the population defined by law/government regulation.	Contributory: based upon a purchase of an insurance policy from a selected health insurance company (or other agency involved)	Compulsory: health insurance premiums. Tax credits may also be involved	National, sub-national, or by scheme; with multiple funds, extent of pooling will depend on risk-equalization mechanisms across schemes. Also depends on the extent of regulation of premium and standardisation of benefits across schemes;
HF.1.3 Compulsory Medical Saving Accounts (CMSA)	Mandatory: for all citizens/residents or a specific group of the population defined by law/government regulation.	Contributory: Based upon the purchase of MSAs. Persons having MSAs can, however, only use the money saved, regardless of whether the saving covers the costs of the care necessary	Compulsory, defined by law (e.g., as percent share of income)	No inter-personal coverage (except perhaps family members).
HF.2.1 Voluntary health insurance schemes	**Voluntary**	**Contributory: based upon the purchase of voluntary health insurance policy (usually on the basis of a contract)**	**Usually a non-income related premium (often directly or indirectly risk-related). Government may directly or indirectly (e.g. tax credits) subsidize.**	**Scheme level;**
HF.2.2 Non-profit Institution financing schemes	**Voluntary**	**Non-contributory, discretionary**	**Donations from the general public, governments (budget of national government or foreign aid) or corporations**	**Varies across programmes, but typically programme-level**
HF.2.3 Enterprise financing schemes (other than employer-based insurance)	**Voluntary choice of particular corporation, with coverage based on employment at such a firm (e.g. compulsory occupational health care)**	**Non-contributory, discretionary with regard to the type of services, though may sometimes be specified by law**	**Voluntary: choice of the firm to use its revenues for this purpose**	**At an individual enterprise level**
HF.3 Household out-of-pocket expenditure	Voluntary: willingness to pay of the household	Contributory: service provided if individual pays	Voluntary: Households disposable income and saving	No inter-personal pooling
HF.4 RoW financing schemes	Compulsory or voluntary	Criteria set by foreign entities	Grants and other voluntary transfers by foreign entities	Varies across programmes

Source: SHA 2011, Table 7.2

Figure A2.1 Criteria tree for health financing



Source: SHA 2011, Figure 7.2

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