ANNEX D

Financing of Health Systems – Supplementary Tools

Classification of Financing Agents (ICHA-FA)

This annex complements Chapter 7 "Classification of financing schemes" with the Classification of Financing Agents. Chapter 7 discusses, among other things, the concept of institutional units of the health system and financing agents as elements of the accounting framework for health financing. Chapter 7 also presents the relationship between financing schemes and financing agents.

Definition of financing agents

A financing agent is an institutional unit involved in the management of one or more financing scheme. It may collect revenues, pay for (purchase) services under the given health financing scheme(s), and be involved in the management and regulation of health financing.

A financing agent may manage the payment for health services and goods in different ways:

- Finance the services produced in its own institutions (*e.g.*, a local government may own and finance a hospital);
- Purchase services from providers owned by other entities (*e.g.*, social insurance funds purchase services from hospitals owned by local governments);
- Reimburse the cost of services to the patients who first pay the bill directly to the providers.

Main categories of the Classification of Financing Agents

- *FA.1 General government*

This item comprises all institutional units of central, state, regional or local government, and social insurance funds.[1] Included are non-market non-profit institutions that are controlled and mainly financed by government units.

Note: FA.1 does not include public corporations, even when all the equity of such corporations is owned by governments units. It also does not include quasi-corporations that are owned and controlled by government units (see SNA 2008, Chapter 4).

Table D.1.1. **Classification of financing agents**

Code	Description
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 (NPISH)**
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

Source: IHAT for SHA 2011.

FA.1.1 Central government

This item comprises all institutional units making up the central government. These entities would not necessarily be just the health ministry, but any central government entity involved in the financing of the health sector. Included are centralised, national level agencies strongly controlled by the central government, such as the National Health Service Agency and National Health Insurance Agency.

Note:

- A central government unit generally acts as financing agent for a governmental scheme (HF.1.1).
- Governmental schemes (HF.1.1) are generally managed by government units. However, NPISH or corporations may also act as financing agents for such schemes. For example, the Ministry of Health may design and set a separate budget for a cancer screening programme, but contract out the financial management to an NPISH or a management company, which then will contract providers to make the screening examinations.

FA.1.1.3 National Health Service Agency

In several countries, universal access to basic health services is ensured by a central government funded and managed programme: the National Health Service Agency (NHSA) is a centralised government agency managing the National Health Service (part of HF1.1.1), usually under the supervision of the Ministry of Health. The NHSA is usually also responsible for provision of the health services, but the NHSA may also purchase services from private providers. The NHSA has a separate legal identity, a separate budget and a certain level of

autonomy and discretion over the allocation of its expenditure. As it is controlled by the central government, it is considered part of the central government sub-sector.

FA.1.1.4 National Health Insurance Agency

Social health insurance schemes (HF.1.2.1) may involve different ways of pooling the financial resources. A country may have a centralised national insurance fund, or a decentralised structure of funds. In the case of a decentralised system, pooling may be based on a territorial or professional principle or funds may compete with each other.

The National Health Insurance Agency is a centralised government agency for managing social health insurance schemes (HF.1.2.1). It has a separate legal identity, a separate budget and a certain level of autonomy and discretion over the allocation of its expenditure. As it is controlled by the central government, it is considered part of the central government sub-sector.

Note: Social health insurance (HF.1.2.1) is a financing scheme characterised by a great variety of institutional arrangements in different countries. Social health insurance can be managed by different financing agents: a centralised national agency (FA.1.1.4.), social insurance funds (FA.1.3) or insurance corporations (FA.2). In some countries, social health insurance may be managed by both government agencies and commercial insurance companies at the same time (for example, in the Slovak Republic).

FA.1.2 State/Regional/Local government

This item comprises all institutional units making up local government. The terms "state" and "provincial" may be used for "regional" in different countries. In small countries, individual state/provincial governments may not exist.

Regional/local governments may act for different financing schemes:

- Regional/local governments may have the primary responsibility for providing access to health care and thus establish their health financing scheme for this purpose. In this case, regional/local governments act as the financing agent for regional/local governmental schemes HF.1.1.2.
- Regional/local governments may also manage central governmental schemes (HF.1.1.1).

FA.1.3 Social security agency

Social insurance funds are economic units with a specific legal status whose purpose is to operate social insurance schemes (HF.1.2.1). They have a non-profit status. They have substantial autonomy in their operations, *e.g.* engaging in financial transactions, and they hold their own assets and liabilities. They are classified as part of the general government sector, as their operation is controlled by the government. Social insurance funds may operate one or more types of social insurance (pension, health, accident, long-term care, etc.).

Note: Recent reforms have brought considerable changes: in some countries, for-profit insurance companies may also be allowed to participate in the operation of a social insurance scheme. Thus, both sickness funds and private insurance companies may take part in the operation of a social health insurance scheme.

FA.1.3.1 Social health insurance agency

Social health insurance agencies[2] are legal entities with the obligation, defined by law, to ensure access to a defined health service package. Social health insurance funds have a non-profit status and are based on the principle of self-governance through representatives of the insured and the employers. Traditionally, social health insurance funds directly collect contributions from their members, and have the right to determine what contribution rate is necessary to cover expenditure. (Reforms over the last two or three decades have changed the characteristics of revenue collection in several countries.)

FA.1.3.2 Other social security agencies

Other social security agencies may also be involved in operating social health insurance or voluntary insurance schemes. For example, in Germany accident funds cover curative and rehabilitative care services for work-related accidents and diseases; retirement funds are responsible for some rehabilitative measures; and long-term care funds manage the long-term care insurance.

FA.1.9 All other public units

This item includes non-market non-profit institutions that are controlled and mainly financed by government units.

- *FA.2 Insurance corporations*

Insurance corporations may act as financing agent for different types of insurance. Traditionally, insurance corporations offer voluntary health insurance (HF.2.1). However, due to recent reforms, in several countries insurance corporations take part in operating compulsory health insurance (HF.1.2.1 or HF.1.2.2). In these countries, an insurance corporation may act as financing agent both for compulsory insurance and voluntary insurance at the same time.

- *FA.3 Corporations (other than insurance corporations)*

Based on the SNA, the category of corporations is used in a wider sense: this sector comprises all corporations or quasi-corporations whose principal activity is the production of market goods or services. Included are all resident government-owned and non-profit institutions that are market producers of goods or non-financial services. Included are non-profit health maintenance organisations and health management corporations managing insurance schemes.

In several countries, there exist a variety of health sector-specific corporations other than traditional health service providers, such as *health management corporations*. These may act as financing agents for several types of financing schemes.

Corporations (including health management corporations) may act as financing agents for:

- Enterprises health financing schemes (H.F.2.3);
- Employer-based insurance (HF.2.1.1.1) and other voluntary health insurance schemes;
- Governmental schemes (HF.1.1); and
- RoW financing schemes (HF.4).

• *FA.4 Non-profit institutions serving households (NPISH)*

Non-profit institutions serving households (NPISH) are a special type of non-profit organisation. NPISH consist of non-profit institutions that provide financial assistance, goods or services to households free or at prices that are not economically significant. Their operation is not controlled by the government.

NPISH may act as financing agent for different financing schemes:

- Non-profit institutions financing schemes (HF.2.2);
- Governmental schemes (HF.1.1);
- RoW financing schemes (HF.4).

Included are charities, relief or aid agencies that are created for philanthropic purposes and not to serve the interests of the members of the association controlling the NPISH. These NPISH provide goods or services on a non-market basis to households in need. The resources of such NPISH are provided mainly by donations in cash or in kind from the general public, corporations or governments. They may also be provided by transfers from foreign entities, including similar kinds of NPISH that are resident in other countries (see SNA 2008, 4.169).

Religious institutions are treated as NPISH, even when mainly financed by government units if this majority financing is not seen as empowering control by the government.

Note: Experience has shown that there is ambiguity in distinguishing between the different types of non-profit organisations (market producers, units of government and NPISH), and also between the different roles that NPISH may play. Therefore, when producing NHAs, it is important to make a qualitative analysis to distinguish between these different roles and statuses of non-profit organisations.

Non-profit institutions may have specific health programmes (with separate funds and management of the funds) and carry out the programmes themselves (as providers of care) or finance health care providers that do so. In this case, the financing scheme is: Non-profit institutions financing scheme, with NPISH playing the role of financing agents. The funds may be provided by households, government, foreign entities or foundations, so that they themselves do not manage the health programmes – they only provide resources for them.

Non-profit institutions that provide assistance to households to buy certain health services (for example, abroad) are considered financing agents, even when the households first pay the bill directly for the services to the providers and are then reimbursed by the NPISH.

• *FA.5 Households*

A household is defined by the SNA as a group of persons who share the same living accommodation, who pool some, or all, of their income and wealth, and who consume certain types of goods and services collectively, mainly housing and food.

Under SHA 2011, households are categorised as the financing agent for households' out-of-pocket payments.

• *FA.6 Rest of the world*

This item comprises institutional units that are resident abroad:

- International and supranational agencies;
- Foreign governments;
- Financial intermediaries (insurance, NGOs, charities and foundations).

RoW institutional units may act as financing agents for RoW-funded schemes (HF.4).

Sectoral accounts

The HFxFS table provides aggregate information about revenue collection in the whole health care sector. There may be a need for more in-depth information about the collection and use of resources concerning major financing schemes that is separate from the HFxFS table. Sectoral accounts can provide important information from the perspective of a given financing scheme or institutional units/sectors that cannot be directly gained from any of the SHA tables; for example, the operating balance (surplus or deficit) of the financing schemes.

In the following, three types of sectoral accounts are presented:

- Sectoral accounts of *revenues and expenses of financing schemes* (except households[3]). The approach of these accounts is similar to the way the Government Finance Statistics Manual (GFSM) accounts for government revenues and expenses. For example, Table D.1.2 presents the account of revenues and expenses of governmental health financing schemes (HF.1.1).
- Sectoral accounts of *health-specific revenues and expenses of institutional units/sectors of the economy.* For example, Table D.1.4 presents the account of total health-specific revenues and expenses of government (including expenses made by government as providers of financial resources).
- The sectoral account of private *households' health-specific transfers and net financing of health care out of own resources.* This shows the overall role of households in health care financing from a macroeconomic perspective. This account is taken from SHA Manual 1.0, which applies an approach similar to the way the SNA accounts for transactions. Such a sectoral account can be produced for all the institutional sectors (as presented in SHA 1.0).

Guidelines available separately from this Manual will be developed for the preparation of sectoral accounts.

The classification of expenses

Based on the GFSM, two approaches can be applied in classifying expenses: an economic or a functional classification of expenses. Sectoral accounts can be useful in both ways.

Table D.1.2 provides an illustration for the accounts of revenues and expenses of financial schemes, using the category of governmental health financing schemes as an example.

Table D.1.2 shows revenue collection and allocation of financial resources under governmental health financing schemes (HF.1.1). The shaded cells in the table are those categories of expenses that cannot occur in this case. Expenses show both expenses on services and goods provided by government units (E1, E2 and E3) and services and goods purchased from providers outside the government sector (E5, E7). This table excludes those

expenses that relate to the role of government as a financing source (FS) for other financing schemes (such as expenditure on grants).

Note: In Table D.1.2 "Expense on social benefits" is a narrower category than health services and goods financed by government. Health services and goods produced by a government unit (*e.g.*, hospitals managed by local governments) are not classified as social benefits. The expenses of producing such services are part of compensation of employees, use of goods and services and consumption of fixed capital.

Table D.1.2. **Revenues and expenses of governmental health financing schemes (HF.1.1)**

	Expenses		Revenues
E1	Compensation of employees	**FS.1**	**Transfers from government domestic revenue**
E.1.1	Wages and salaries	FS.1.1	Internal transfers and grants
		FS.2	**Transfers distributed by government from foreign origin**
E.1.2.	Social contribution	**FS.6**	**Other domestic revenues *n.e.c.***
E2	Use of goods and services	FS.6.1	Other revenues from households *n.e.c.*
E3	Consumption of fixed capital	FS.6.2	Other revenues from corporations *n.e.c.*
E4	Interest	FS.6.3	Other revenues from NPISH *n.e.c.*
E5	Subsidies	**FS.7**	**Direct foreign transfers**
E6	Grants	**FS.7.1**	**Direct foreign financial transfers**
E7	Social benefits	FS.7.1.1	Direct bilateral financial transfers
E8	Other expense	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 technical assistance – TA)
		FS.7.3	Other direct foreign transfers (*n.e.c.*)
Net/gross operating balance			

*: For the definition of the categories of expenses, see: Government Finance Statistics Manual, www.imf.org/external/pubs/ft/gfs/manual/pdf/all.pdf.
Source: IHAT for SHA 2011.

Revenue less expenses equals the *net operating balance*, which is an important summary measure of the sustainability of the given financing scheme. (The gross operating balance equals revenue minus expenses other than consumption of fixed capital.)

Table D.1.2 shows the account of governmental financing schemes with a functional classification of health expenditure (ICHA-HC).[4]

Sectoral accounts of health-specific revenues and expenses of institutional units

This type of account includes all health-specific revenues and expenses of the main types of institutional units of the health system, regardless of whether these relate to their role as financing agent or as provider of financial resources. Table D.1.4 serves as an example, presenting total health-specific revenues and expenses of the government.

The sectoral account of total health-specific revenues and expenses of the government (Table D.1.4) concerns all components of government involvement in health care financing, including their roles as financing agent and provider of financial resources. For example, under its role as a provider of financial resources, government may provide

Table D.1.3. **Revenues and expenses of governmental health financing schemes (HF.1.1)**

	Expenses		Revenues
HC.1	Curative care	**FS.1**	**Transfers from government domestic revenue**
HC.2	Rehabilitative care	FS.1.1	Internal transfers and grants
HC.3	Long-term care (health)	**FS.2**	**Transfers distributed by government from foreign origin**
HC.4	Ancillary services non-specified by function	**FS.6**	**Other domestic revenues *n.e.c.***
HC.5	Medical goods non-specified by function	FS.6.1	Other revenues from households *n.e.c.*
HC.6	Preventive care	FS.6.2	Other revenues from corporations *n.e.c.*
HC.7	Governance and health system & financing administration	FS.6.3	Other revenues from NPISH *n.e.c.*
HC.9	Other health care services not elsewhere classified (*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.*)
Net/gross operating balance			

Source: IHAT for SHA 2011.

grants to an NPISH which acts as a financing scheme, *e.g.* to pay social contributions on behalf of children or elderly persons to compulsory social insurance schemes and so on.

The sectoral account of government (as an institutional sector) includes 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.

The accounting of private households health-specific transactions and net financing out of own resources

The purpose of the account of private households' health-specific transactions and net financing of health care out of own resources is to provide a comprehensive macroeconomic view of the households' role in health care financing. This account tracks back the transfers to the level of households' primary income and therefore treats households differently than does the ICHA-FS classification (HFxFS matrix). See Table D.1.5.

The account of private households consists of two parts: the first part shows the transfers that households make and receive *relating to health care financing*. (It does not show households' resources and revenues gained/used for purposes other than health care.) The second part shows the amount of Actual final consumption and how much of Actual final consumption is ultimately financed by households, including not only direct payments, but payments through third-party payers (for which funds originally stem from households' primary income).

Table D.1.4. **Total health-related revenues and expenses of government**

	Expenses		Revenues
E1	Compensation of employees	**FS.1**	**Transfers from government domestic revenue**
E.1.1	Wages and salaries	FS.1.1	Internal transfers and grants
E.1.2.	Social contribution	**FS.3**	**Social insurance contributions**
E2	Use of goods and services	FS.3.1	Social insurance contributions from employees
E3	Consumption of fixed capital	FS.3.3	Social insurance contributions from employers
E4	Interest	FS.3.3	Social insurance contributions from self-employed
E5	Subsidies	FS.3.4	Other social insurance contributions
E6	Grants		
E7	Social benefits	**FS.6**	**Other domestic revenues *n.e.c.***
	Social security benefits	FS.6.1	Other revenues from households *n.e.c.*
	Social assistance benefits	FS.6.2	Other revenues from corporations *n.e.c.*
	Employer social benefits	FS.6.3	Other revenues from NPISH *n.e.c.*
E8	Other expenses	**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.*)
Net/gross operating balance			

*: For the definition of the categories of expenses, see: Government Finance Statistics Manual, www.imf.org/external/pubs/ft/gfs/manual/pdf/all.pdf.
Source: IHAT for SHA 2011.

The account of private households' health-specific transfers provides the following information:

- The "uses" side shows all the transfers that households make relating to health care financing. The source of these payments is households' incomes that, however, are not explicitly shown in this account.
- The "resources" side shows all the health-specific transfers and benefits that households receive, including benefits in-kind.
- The "Net balance of health specific transfers" shows the difference between transfers made and received. This is the amount by which households' health-specific transfers received from other actors of the economy (mostly benefits in-kind and in-cash) exceed the health-related transfers that households made.[5]
- This part of the account, however, does not show explicitly the out-of-pocket payments that households make for health services (as they are not transfers). This amount can be calculated from the second part of the account.

The second part of the account shows, tracing back to primary incomes, ultimately, to what extent households' own resources cover the actual individual consumption of health services.

- "Actual final consumption" shows the total resources devoted to health care financing, except gross capital formation. Actual individual consumption refers to services consumed

by individuals (regardless of who pays for it), and Actual collective consumption refers to those services that are a public good, in an economic sense (that is consumption by one individual does not exclude others from consumption of the same services). Examples are anti-smoking advertisements and health care administration.

- "Net financing of health care out of own resources" shows the total amount households devoted to health care from their primary income: this is partly channelled through third-party payers (health-specific transfers) and out-of-pocket payments paid directly to providers. This latter amount (OOPs) can be calculated as the difference between "Net financing of health care out of own resources" and the sum of the transfers made by households; or as the difference between actual individual consumption and transfers received by households. (In the example, OOP amounts to 375.)

Table D.1.5. **Account of households' health-specific transfers and net financing out of own resources**

	Uses			Resources	
D.51	Tax deduction (per household)	–22	**D.62**	Social benefits other than social transfers in kind	97
			D.621	Social security benefits in cash	8
D.61	Social contributions	651	D.622	Private funded social benefits	75
D.611	Actual social contributions	639	D.623	Unfunded employee social benefits	9
D.6111	Employers' actual social contributions	322	D.624	Social assistance benefits in cash	5
D.6112	Employees' actual social contributions	241			
D.6113	Social contributions by self- and non-employed persons	76	**D.63**	Social transfers in kind	749
D.612	Imputed social contributions	12	D.631	Social benefits in kind	720
			D.6311	Social security benefits, reimbursements	313
D.7	Other current transfers	59	D.6312	Other social security benefits in kind	372
D.71	Net insurance premiums	51	D.6313	Social assistance benefits in kind	35
D.75	Miscellaneous current transfers	8	D.632	Transfers of individual non-market goods and services (charity from NPISH)	29
			D.7	Other current transfers	109
			D.72	Net insurance claims	50
			D.75	Miscellaneous current transfers	59
B.1	*Net balance of health specific transfers*	267			
			B.1	*Net balance of health-specific transfers*	267
P.4	Actual final consumption	1330			
P.41	Actual individual consumption	1330			
P.42	Actual collective consumption				
B.2	*Net financing of health care out of own resources*	-1063			

Source: SHA Manual, 1.0, p. 82.

The accounts presented in the main text and Tables in this annex describe health care financing from three different perspectives:

- Focusing on financing schemes (direct or third-party payers). For example, in the case of households as a financing scheme (HF.3), only out-of-pocket payments are accounted;

- Focusing on financing sources. For example, in the case of households as a provider of financial resources, social and voluntary insurance contributions paid by households, etc., are also accounted for (besides out-of-pocket payments);
- Focusing on, based on the SNA, the net balance of own resources devoted by institutional sectors of the economy to health care financing. As already mentioned, in the case of households, all social contributions (including employers' social contributions) are reported as uses (expenses of) households.

An in-depth analysis of households could be made from the comparison of these three approaches.

Main problems of the health financing classification (ICHA-HF) in SHA 1.0

Over time, a number of problems both from health policy and health accounting perspectives have emerged with the ICHA-HF classification in SHA 1.0. The classification for health care financing under SHA 1.0 is shown below in Table D.1.6.

Table D.1.6. **ICHA-HF classification of health care financing in SHA 1.0**

ICHA-HF code (SHA 1.0)	ICHA-HF category
HF.1	**General government**
HF.1.1	General government excluding social security funds
F.1.1.1	Central government
HF.1.1.2	State/provincial government
HF.1.1.3	Local/municipal government
HF.1.2	Social security funds
HF.2	**Private sector**
HF.2.1	Private social insurance
HF.2.2	Private insurance enterprises (other than social insurance)
HF.2.3	Private household out-of-pocket expenditure
HF.2.3.1	Out-of-pocket excluding cost-sharing
HF.2.3.2	Cost-sharing: Central government
HF.2.3.3	Cost-sharing: State/provincial government
HF.2.3.4	Cost-sharing: Local/municipal government
HF.2.3.5	Cost-sharing: Social security funds
HF.2.3.6	Cost-sharing: Private social insurance
HF.2.3.7	Cost-sharing: Other private insurance
HF.2.3.9	All other cost-sharing
HF.2.4	Non-profit institutions serving households (other than social insurance)
HF.2.5	Corporations (other than health insurance)
HF.3	Rest of the world

Source: IHAT for SHA 2011.

The categories of ICHA-HF in SHA 1.0 do not adequately reflect the complex and changing systems of health financing

In both the OECD area and in middle- and lower-income countries outside the OECD, insurance and financing schemes are heterogeneous and have evolved significantly as a result of recent reforms and policy initiatives (Gottret and Schieber, 2006; OECD, 2004). A few examples are listed below, illustrating that the categories of ICHA-HF in SHA 1.0 do not enable the complex and changing systems of health financing to be reflected adequately:

- In the Netherlands prior to 2006, non-profit sickness funds operated the social insurance scheme; and they were accounted under HF.1.2. Social security funds. Following the 2006 reform, the same purpose, that is, to provide access to care for the whole population, is

performed by compulsory health insurance that is managed by private insurance enterprises. If the definitions of ICHA-HF were strictly applied, this expenditure should be accounted under HF.2.2 Private insurance enterprises. However, health spending would not be comparable with the previous Dutch system, nor that of other OECD countries. In fact, Netherlands reported expenditure by compulsory insurance funds under HF.1 General government. Strictly speaking, this is not appropriate. Furthermore, the same insurance companies also offer voluntary health insurance, which is accounted for under HF.2.2. If the SHA 1.0 definitions of ICHA-HF were strictly applied, payment under both mandatory cover and voluntary health insurance should be counted under HF.2.2.

- In the Slovak Republic, the compulsory social insurance scheme is managed by a state-owned insurance agency and also by private insurance enterprises. Thus the same role is played by institutional units belonging to the general government and institutional units belonging to private insurance enterprises. Strictly speaking, according to the ICHA-HF in SHA 1.0, spending by the state-owned insurance agency should be reported under HF.1.2 and spending by the other insurers under HF.2.2 Private insurance enterprises. This obviously would not be appropriate.
- The spending by the U.S. Medicare programme is reported under HF.1 General government. However, beneficiaries are allowed to obtain Medicare coverage through certain private health insurers if they want, or they can remain in the traditional Medicare programme. These private health insurers (primarily managed care plans) act for the government. According to the SHA 1.0 ICHA-HF, in a strict sense, expenditure by private insurers should be classified as HF.2.2 Private insurance enterprises.
- In Switzerland, basic health insurance is mandatory for the entire resident population. Mandatory health insurance is provided by private funds, but their activity is heavily regulated (OECD, 2006b). Several insurers that offer mandatory health insurance also sell voluntary health insurance, which is not subject to stringent regulation. Mandatory health insurance in Switzerland is at present reported under HF.1.2 Social security funds (as part of General government). If Switzerland classified mandatory health insurance according to the ICHA-HF classification and criteria in SHA 1.0, both mandatory and voluntary insurance should appear under "private insurance" (HF.2.1 or HF.2.2) as part of private sector financing (HF.2). While it is not correct to report the Swiss mandatory system under "social security", it would not be satisfactory to place it with voluntary health insurance under the category private health insurance.
- In some middle- and lower-income countries, there are specific arrangements for health care financing, such as community insurance and medical savings accounts, which would require new categories, as their decisive characteristics are not reflected by any of the categories of ICHA-HF in SHA 1.0.

In fact, in most of the above-mentioned cases, countries apply a practical approach that best reflects the nature of the financing arrangements: as if the ICHA-HF categories were defined as financing schemes. (In a strict sense, this means that some of the data – according to SHA 1.0 – are "misclassified" by countries.)

Ambiguity regarding the current definitions of the ICHA-HF categories

There is a great deal of ambiguity regarding the definitions of the ICHA-HF categories: SHA 1.0 did not make a clear distinction between financing schemes and institutional units (organisations) that manage financing schemes.

The definitions provided in SHA 1.0 for several categories can be interpreted in two different ways: as schemes or as institutional units (which, however, may manage more than one different scheme). For example:

- HF.1 General government: "This item comprises *all institutional units* of central, state or local governments and social security funds on all levels of government."
- HF.1.2 Social security funds: "Social security funds are social insurance *schemes covering the community as a whole,* or large sections of the community, and that are imposed and controlled by government units."
- HF.2 Private sector: "This sector comprises all resident institutional units which do not belong to the government sector."
- HF.2.2 Private insurance enterprises (other than social insurance): "This sector comprises all private *insurance enterprises* other than social insurance. Note: this sector comprises both *for-profit and non-for-profit insurance schemes* other than social insurance."

HF.2.3 "Private households' out-of-pocket expenditure" obviously is not a category for an institutional sector. (Households as an institutional sector also pay social insurance contributions and voluntary insurance fees.)

One source of this ambiguity between schemes and institutional units is that the definitions for most of the categories of ICHA-HF in SHA 1.0 were taken from SNA 93 (definitions for the institutional sectors) without adequate interpretation for the health care sector. Furthermore, health systems have undergone considerable changes since SNA 93 was prepared that the SNA obviously cannot reflect.

In fact, in the cases of a few countries (*e.g.*, Netherlands, Slovak Republic, Switzerland, etc.), a decision already had to be made about whether to apply a financing scheme or an institutional approach. In all cases, countries applied a financing scheme approach, as that more accurately reflected the characteristics of their financing systems. (In a strict sense, however, there is a discrepancy between the ICHA-HF definitions under SHA 1.0 and the new schemes. This is one of the key reasons for the revision of the ICHA-HF.)

What information is expected from SHA 2011?

To answer this question, our starting point is SHA 1.0. It emphasises:

"*The set of core tables in the System of Health Accounts (SHA) addresses three basic questions*:

- Where does the money come from (source of funding)?
- Where does the money go to (provider of health services and goods)?
- What kind of (functionally defined) services are performed and what types of goods are purchased?

Consequently, SHA is organised around a tri-axial system for the recording of health expenditure, by means of a newly proposed International Classification for Health Accounts (ICHA), defining:

- Health care by function (ICHA-HC);

- Health care service provider industries (ICHA-HP);
- Sources of funding health care (ICHA-HF)."

In fact, the HCxHF and HCxHP tables reflect the answer to the first question from the perspective of the providers. It would be more precise to say: Where does the money come from that is *received by the providers*.

During the implementation of SHA, the ambiguity regarding the "where does the money come from" question resulted in changes in the name of the ICHA-HF classification. The JHAQ 2006 used two terms: financing agent/financing schemes, reflecting the lack of agreement.

The SHA 2011 Revision consultation process thoroughly discussed whether ICHA-HF should be defined as a Classification of Financing Schemes or as Classification of Financing Agents (institutional units).

Concerning the interpretation of "where", two approaches can be applied:

- *From a health policy perspective*, the "where" should refer to the main "building blocks" of the health financing system of a country: government programmes, compulsory insurance, voluntary insurance, out-of-pocket payment, etc. From a health policy perspective, the tri-axial system (HCxHF and HPxHF tables) should provide information focusing on *how the resources of the main financing schemes are allocated among services/providers*.
- *From a statistical/micro-economic perspective*, the "where" refers to the economic units executing the payments. If the ICHA-HF were defined as a classification for financing agents (institutional units), the HCxHF and HPxHF tables would provide information concerning the economic units executing the payments to the providers, *regardless of the financing schemes they manage*.

To highlight the differences between the two perspectives, take the following example. In a given country, private insurance companies manage both compulsory and voluntary insurance:

- The key health policy focus is on the difference between the spending by the compulsory insurance scheme and by the voluntary insurance scheme (regardless of which economic units execute the payment under the compulsory insurance scheme);
- The micro-economic focus is on the operation of private insurance companies. However, even in this case the data that includes payments under both compulsory insurance and voluntary insurance are not very meaningful. Information would be needed about financing schemes and institutional units together.

Conclusion for the interpretation of the ICHA-HF classification

The essential information needs for health policy analysis is what puts the health financing schemes at the centre of the accounting framework for health financing under SHA 2011. Therefore, ICHA-HF is interpreted as a Classification for Financing Schemes.

This does not mean, however, that the institutional settings of the allocation of resources and revenue-raising are not important. The proposal for a Classification of Financing Agents (ICHA-FA) and the relevant tables (Expenditure by functions, financing schemes and financing agents and expenditure by providers, financing schemes and financing agents) address this issue.

Notes

1. In SNA the relevant terminology is: social security funds. In the literature on health financing generally the expression "social insurance fund" or "sickness fund" is used.
2. In some countries, social insurance funds are called sickness funds. In many European countries, when compulsory social health insurance for industrial workers was introduced in the late 19th or early 20th century, its operation was built on the organisational structure of the voluntary self-help and self-regulatory funds established by the industrial workers to alleviate the risk of poverty due to sickness and death. The period since the 1960s has witnessed the increasing involvement of state regulations and a considerable concentration of the number of funds. For example, in Germany there were more than 2000 sickness funds in the early 1960s but only about 300 in the early 2000s (Busse and Riesberg, 2004).
3. Under ICHA-HF, only households' out-of-pocket expenditures are accounted under households (HF.2.2.). Producing a sectoral account for households' direct purchase of health services and goods would not provide additional information to the HFxFS table.
4. The table shows only the first-digit level categories of ICHA-HC.
5. Technically, the two sides of the T-account should be equal. Therefore a positive net balance (on the "uses" side) means that the transfers received exceeds the transfers made. A negative net balance means that the transfers made exceed the transfers received of the given actors.