PART I

Chapter 7

Classification of Health Care Financing Schemes (ICHA-HF)

Introduction

This chapter presents a summary of the conceptual accounting framework for health financing and of one of its main components, the new classification of health care financing schemes (ICHA-HF). This summary also serves as an introduction to Chapter 8, in which the classification of revenue of financing schemes (ICHA-FS) is presented. Furthermore, in SHA 2011 the accounting framework for health care financing also encompasses the concept of institutional units of health financing and the related classification of financing agents (ICHA-FA) as a tool for a more detailed national analysis (see Annex D). The three classifications together provide the tools to account comprehensively for health care financing and describe the flow of financial resources in the health system. This introduction therefore provides a brief definition of all the key concepts and highlights their relationships. The relevance of the particular classifications and cross-tabulations may vary for countries that differ in the organisational structure and level of resources of their health care systems, as well as in their level of economic development and their dependency on foreign resources.

This chapter is concerned with the financing of the final consumption of health care goods and services; Chapter 11 discusses the financing of fixed capital formation. As to the main functions of health financing, Chapter 7 focuses on accounting tools for the allocation of resources; while Chapter 8 focuses on accounting tools for revenue-raising.

The aim of the accounting framework for health financing is to help health accountants and analysts obtain a clear and transparent picture of health financing systems, including information that is relevant to health policy about the structure and flows of funds (transactions). This includes indicators – comparable across countries and over time – that can contribute to the assessment of the performance of health financing systems.

Health financing systems mobilise and allocate money, within the health system, to meet the current health needs of the population (individual and collective), with a view to expected future needs. Individuals may have access to care by means of direct payment for services and goods or through third-party financing arrangements, such as with a National Health Service, social insurance or voluntary insurance.

The concept of health care financing schemes is an application and extension of the concept of social protection schemes defined by the European System of Integrated Social Protection Statistics (ESSPROS). The ESSPROS Manual emphasises: “the scheme concept of social protection [is straightforward as it] starts from the point of view of the beneficiaries”. As health policy is primarily concerned with ensuring access to health care, the approach of ESSPROS is considered to be a highly relevant starting point.

ESSPROS defines social protection schemes as follows: “A social protection scheme is a distinct body of rules, supported by one or more institutional units, governing the provision of social protection benefits and their financing …. Institutional units can

support more than one social protection scheme, when they administer and provide very diverse types of social benefits. On the other hand, a single social protection scheme can be supported by several institutional units …. The *body of rules* referred to in this definition may be established *de jure*, by virtue of laws, regulations or contracts, or *de facto*, by virtue of administrative practice…".

The *structure* of a health care financing system consists of two types of entities: *financing schemes* (such as national health service, social health insurance and voluntary insurance, and so on) *and institutional units* (financing agents, such as government units, a social security agency, private insurance corporations and so on) that in practice operate the financing schemes. A social insurance scheme, for example, defines who is obliged to participate in the scheme, what is the basis for entitlement to health care and what benefits the scheme offers as well as the rules on raising and pooling the social insurance contributions. The scheme may be operated by a single government agency or by specific insurance funds or by a government agency and insurance companies at the same time. *The operation* of a health financing system entails transactions by the three main functions of health financing: revenue-raising, pooling and purchasing – such as, for example, payment of social insurance contributions to a single national fund and distribution of the resources, first among the different purchasing organisations, and then among the services and their providers. The transactions are executed by the financing agents, according to the rules of the financing schemes.

The SHA framework for the accounting of health care financing makes it possible to analyse the following major issues:[1]

- How does a particular financing scheme collect its revenues? (HFxFS tables);
- From which institutional units of the economy are the revenues of a particular financing scheme mobilised? (HFxFS.RI[2]; and HFxFSxFS.RI);
- Through what kind of financing arrangements do people have access to care? The role (share) of the main financing schemes[3] in a country's health care sector (HF table);
- 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? [HCxHF table];
- How are the particular health care services or goods financed? For example, what share of the spending on inpatient care is covered by compulsory insurance, voluntary insurance and out-of-pocket (OOP) payments? (HCxHF table);
- How are the resources of the different financing schemes allocated among the different groups of beneficiaries, such as different groups of diseases? (BeneficiariesxHF table);
- "Where does the money go?" From which providers are the services purchased under the particular financing schemes? (HPxHF table);
- How is health care financing managed in a country? What kind of institutional arrangements govern the funds of financing schemes? What changes have occurred in the institutional arrangement of health care financing in a given period? (HFxFA table).

Main concept

Summary of the accounting framework for health care financing

The aim of the accounting framework for health care financing is to provide a clear and transparent picture of a country's key transactions (flows) and the structure of its health financing system. A comprehensive accounting of the financing flows requires tools for accounting the transactions of revenue-raising and resource-allocation, as well as the institutional units involved.

The accounting framework for health financing consists of the following main components:

- Key concepts and definitions;
- Classifications (Chapters 7 and 8 and Annex D);
- Accounts (tables): accounts for the allocation of resources; and accounts for revenue-raising (Chapter 15 and Annex D);
- Key indicators;
- Accounts for sectoral analysis of the main health care financing schemes and institutional units (Annex D).

Key concepts

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

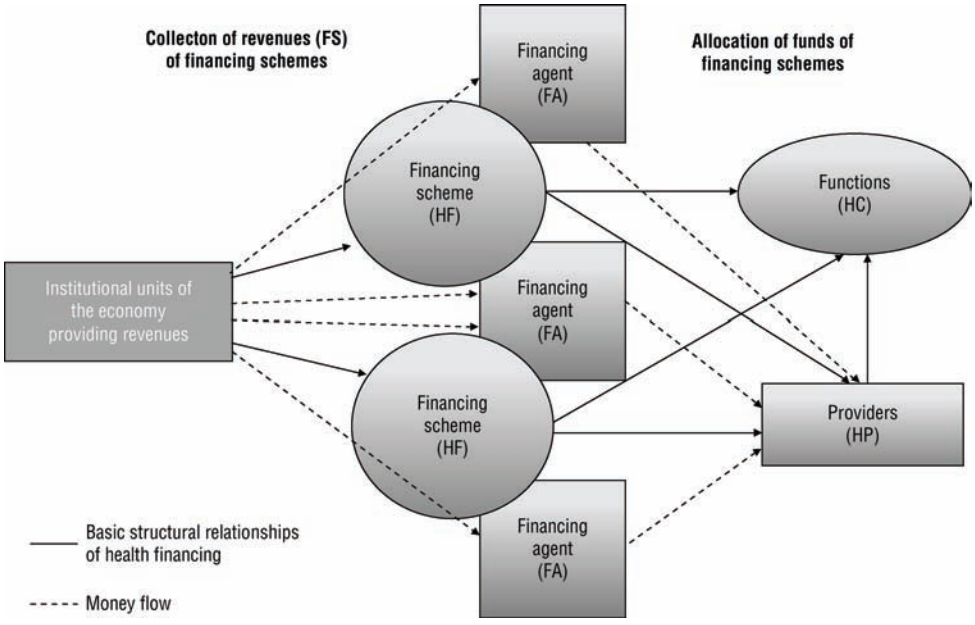
Key concepts under SHA 2011 for describing the structure of the financing system and its key transactions are as follows:[4]

- *Health care financing schemes* as the main "building blocks" of the functional structure of a country's health financing system: the main types of financing arrangements through which health services are paid for and obtained by people. Examples include direct payments by households and third-party financing arrangements, such as social health insurance, voluntary insurance, etc. Although the financing schemes in this framework are key for purchasing health care, they also include the rules for other functions, such as the collection and pooling of the resources of the given financing scheme.[5]
- *Types of revenues* of health care financing schemes: the approach used 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 and grants to sustain the non-profit organisation schemes). Measurement of the revenue sources of each financing scheme, as well as for the system as a whole, provides essential information to policy makers, particularly on the mix of public and private expenditures (see Chapter 8).
- *Institutional units* of health care financing systems that may play the role of providers of revenues for financing schemes (such as households and corporations); and/or the role of financing agents that manage one or more financing schemes. *Financing agents* are institutional units that administer health financing schemes in practice: they implement the revenue collection and/or the purchasing of services. Examples include local governments, social insurance agencies, private insurance companies, non-profit organisations and so on. (The structure of the financing agents does not always reflect

the functional arrangements to cover the purchasing and paying strategies in health systems.)

Figure 7.1 shows the relationships between these key entities of the health financing system.

Figure 7.1. **A graphical representation of SHA 2011 financing framework**



Source: IHAT for SHA 2011.

The key concepts for describing the structure of the health financing system under SHA 2011 are based on measuring *a)* the expenditure of *health care financing schemes*, under which goods and services are purchased directly from health care providers, on the one hand, and *b)* the types of revenues of health care financing schemes, on the other hand (such as government domestic revenues, social insurance contributions, voluntary prepayments and so on). Health care financing schemes are perceived here as the main "building blocks" of the structure of a country's health financing system: they are the main types of financing arrangements through which people can get access to health care, for example government schemes, social insurance and voluntary insurance. Financing agents are perceived here as the institutional units that operate the financing schemes in practice. There is not necessarily a one-to-one correspondence between financing schemes and financing agents. For example, in the Slovak Republic in 2009 the compulsory social insurance was managed by two government-owned agencies and four commercial insurance companies. In the Netherlands, private insurance companies operated compulsory private insurance schemes and voluntary insurance at the same time.[6] In this case, the insurance corporations follow two different types of regulation. For example, they have to accept everybody under the compulsory health insurance, but may apply risk-related premiums and refuse individuals under the voluntary insurance.

There is a need to clearly distinguish, on the one hand, the concepts that make it possible to analyse the financing of the consumption of health care goods and services and, on the other hand, the data collection processes. Health care financing schemes (HF)

are the key units for the analysis of financing the consumption of health care goods and services, while the data concerning the relevant transactions may be collected either from financing agents operating the different financing schemes or from the providers, depending on countries' statistical systems. To put it another way: the categories of health care financing schemes are key analytical units of SHA 2011, for which data are collected from financing agents or providers (see the section on *Specific conceptual issues* later in this chapter for further details).

Classifications and tables

Health accounts tables can provide information on:

- *How the funds of particular health care financing schemes are allocated;* What services are consumed by individuals or the community as a whole, and from what providers are they purchased under the particular financing schemes? (HCxHF and HPxHF and HCxHPxHF). What institutional units are managing the purchase of services under the particular financing schemes? (HFxFA, HCxHFxFA and HPxHFxFA).
- *How the revenues of particular health care financing schemes are raised:* In what ways do the particular financing schemes collect their revenues? (HFxFS). From which institutional units of the economy are the revenues of a particular financing scheme mobilised? (HFxFS.RI; and HFxFS.RI tables).

Sectoral accounts (see Annex D) are offered as tools for country-specific analysis. Sectoral accounts make it possible to analyse the main health care financing schemes and institutional sectors of the health system separately. Sectoral accounts involve a different organisation of the data, closer to national accounting criteria. They can provide information from the perspective of a given financing scheme or institutional unit (on a national accounting basis, *e.g.* central government, households) that cannot be directly gained from any of the SHA tables.[7] For example, a sectoral account of the government presents – in the form of a T-account – the total health-specific revenues (on the right-side of the T-account) and expenses of government, including both payment to providers and transfers made by the government to other financing schemes (on the left-side of the T-account).

Table 7.1 shows the key changes in the accounting framework of health financing in SHA 2011 compared with SHA 1.0. The use of "health care financing" as the general term in SHA 1.0 proved to be too vague, as in a wider sense it may include financing schemes and their revenues, as well as financing agents. Financing agents as a concept remains largely unchanged from the *Producers Guide*. Based on the relevant health policy literature, the SNA and ESSPROS, "health care financing schemes" is regarded as a more suitable term for labelling HF.

The financing framework:

- Is based on the concept of the *financing scheme*, and is analysed through: the financing schemes, the revenue sources of each scheme; and the institutional units (financing agents) managing the schemes;
- Distinguishes between the institutional sectors of the economy providing resources to financing schemes and the flow of these resources, that is, the types of revenues of health care financing schemes (mechanisms of revenue-raising);

Table 7.1. **Key health financing concepts and classifications in SHA 2011 and SHA 1.0/*Producers Guide***

Key concepts	
SHA 2011	SHA 1.0/PG
Health care financing schemes (HF) **Financing agents (institutional units implementing/managing financing schemes) (FA)**	**Health care financing (HF under SHA 1.0) Source of funding (HF under SHA 1.0)** **Financing agent (HF in PG)**
Revenues of health care financing schemes (FS) **Institutional units of the economy[8] providing the revenues of the financing schemes**	Financing sources defined as institutional units (FS under PG)
Classifications	
SHA 2011	SHA 1.0/PG
ICHA-HF Classification of health care financing schemes **ICHA-FA Classification of financing agents**	**ICHA-HF** Classification of health care financing (SHA 1.0) Classification of financing agents (PG)
ICHA-FS Classification of revenues of health care financing schemes	ICHA-FS Classification of financing sources (PG) defined as institutional units

Source: IHAT for SHA 2011.

- Changes the focus from "financing sources" as institutions to the types of revenues of health care financing schemes (transactions), as this is more relevant for health policy analysis;
- Distinguishes between financing schemes (HF) and the institutional units (financing agents: FA) that manage them;
- Interprets financing schemes (HF) as the key functional components of the health financing system, and hence connects them to providers and health care functions in the tri-axial system of the SHA;
- Allows for a distinction between the different roles that institutional units such as the government and households play in a health system (see Figure 7.5);
- Provides possibilities for national analysis to show the relationship *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;
- Provides possibilities for national analysis to link the SHA financing analysis to other statistical systems, *e.g.* to prepare sectoral accounts of the most important financing schemes or financing agents.

In a simple health financing system, there may be one-to-one correspondence among revenues of schemes, financing schemes and financing agents. For example, the National Health Service in a country may be financed only from general government revenues and operated by government units. However, neither theoretically nor in practice is this a typical case. A financing scheme may raise its revenues from several sources, and it can 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.

The definitions of the categories of health care inancing schemes in ICHA-HF are intended to facilitate the reporting of comparable, policy-relevant expenditure data across countries and over time. It should be emphasised that the interpretation of ICHA-HF as a classification of financing schemes would *not* require major changes to the current reporting practice of most countries, in particular those with a one-to-one correspondence between the financing agent and financing scheme. In fact, the revised categories of ICHA-HF in many cases provide a better alignment with current country practices of reporting health expenditure. The revised definition and categories of ICHA-HF are relevant from a health policy point of view and are in accordance with the dominant view of health financing in the health policy literature.

The SHA 2011 HF classification provides additional detail for some of the categories, in particular for voluntary insurance. The relevance of the detailed categories to particular countries will differ according to the specific characteristics of their health care systems.

The concept and main categories of health care financing schemes

Each country's health financing system consists of several "building blocks" in the form of a set of sub-systems or financing arrangements.[9] Key characteristics of a financing sub-system are its coverage (who is entitled to which services) and the features of the basic health financing functions: the collection of funds, the pooling of funds and the purchasing/paying for health services (*i.e.* the allocation of funds to providers and services) (Kutzin, 2001; Mossialos and Dixon, 2002; WHO, 2000). A financing sub-system may involve a mix of contribution mechanisms and a mix of purchasing methods and organisations. For example, social insurance schemes may involve not only compulsory insurance contributions but also transfers from government general revenues.

The legal basis of financing schemes

It is important to consider the legal basis of financing schemes to distinguish compulsory social insurance from compulsory private insurance. Third-party financing schemes may be established and operated as follows: through public law and publically operated; through private law and privately operated; or through public law and privately operated.[10]

- A third-party financing scheme may be established by a specific public law with the purpose of providing protection against the financial risks of ill-health for the society as a whole, or for specific groups in society (employed persons, the most vulnerable groups, etc.). The operation of the financing scheme is also regulated by public law and the operating rules of the institutions involved differ in many respects from the operation of the market economy (government schemes, social health insurance).
- A third-party financing scheme may be created by private economic actors and operated under private law. An example is voluntary health insurance.
- A third-party financing scheme may be established by a specific public law with the purpose of providing protection against the financial risks of ill-health for the society as a whole, or for specific groups in society. However, whether the purchase of a contract is needed is decisive in distinguishing between compulsory private insurance and social health insurance. The day-to-day operation of the financing scheme (involving many elements of the relationship between the insuree and the insurer) is regulated under private law (*e.g.* compulsory private health insurance in the Netherlands).

Criteria for distinguishing the categories of financing schemes

The following list contains the main criteria for distinguishing the different health care financing schemes:

- Resident or non-resident (foreign) scheme with mandatory or voluntary coverage (mode of participation);
- Entitlement – contributory or non-contributory (basis for entitlement);
- Compulsory or voluntary contributions;
- Contribution prepaid or made at the time of service use;
- Pooling is interpersonal or solely for the individual or family;
- Purchase of insurance policy needed or not

The key distinguishing characteristics, from a policy perspective, are:

- Whether participation is compulsory by law (or government regulation) or voluntary; and
- Whether or not entitlement is based on a contribution (made by or on behalf of the covered individuals) or on another criterion, such as citizenship, residency, income/poverty status, etc.

SHA 2011 uses the terms "compulsory" or "mandatory" in the sense of compulsory by law (or government regulation).

However, there are some complex financing arrangements that require further categories of participation and entitlement.

The *mode of participation* refers to the relationship between the individuals (residents of a country) and the different financing schemes, which leads to the following categories:

- Compulsory/mandatory:
  - — Coverage of the population is automatic, universal for all citizens/residents (for example, national health services);
  - — Participation (contribution payment) is mandatory by law for all of the population or for defined groups within the population (social health insurance or compulsory private insurance).
- Voluntary:
  - — Coverage of individuals or groups is at the discretion of individuals or firms (*e.g.* individual- or group-based voluntary health insurance).

The *basis for benefit entitlement* refers to the general conditions (basic rules) for access to care under the different financing schemes. An individual's access to health services under a financing scheme may be:

- Non-contributory: defined by constitution or law (citizens/residents, or defined individuals or groups within the country) and not linked to a specific contribution payment;
- Contributory: defined by law/government regulation and requires a contribution payment made by or on behalf of the covered individual (*e.g.* social health insurance);
- Discretionary: based on the *discretion* of a private entity (charity foundation, employer, foreign entity).

The *method for raising funds* is the mechanism through which the revenues of a particular financing scheme are set and collected. The main types are: government domestic revenues, mandatory income-related insurance contributions, mandatory non-income related premiums, voluntary insurance premiums (risk-related or non-risk-related), other domestic voluntary transfers, foreign transfers and so on. The classification of revenues of health care financing schemes (see Chapter 8) provides only the main types of revenues and does not distinguish several aspects mentioned (*e.g.* between income-related or non-income related insurance premiums). The key distinctions are:

- Compulsory:
  - — Taxation and other sources of general government revenues;
  - — Compulsory prepayment (*e.g.* social health insurance, compulsory private insurance, compulsory Medical Savings Accounts – MSAs).
- Voluntary:
  - — Voluntary health insurance and out-of-pocket payments.

The *mechanism and extent of the pooling and re-allocation of funds* are defined by the regulations of the given scheme. The main types may be income-related contributions pooled at national level; mandated community rating of premiums at national level; community rating of premiums at a local level (financing agent level); and risk-related contributions. In the case of decentralised sub-systems (both health insurance and tax-financed systems), mechanisms may exist for the re-allocation of the revenues raised. In the case of household out-of-pocket payments, no pooling is involved. The key distinctions are:

- Pooled across individuals:
  - — Geographic level, such as national or sub-national;
  - — Scheme level, such as by insurance fund or "programme".
- No inter-personal pooling:
  - — Out-of-pocket payments, compulsory medical savings accounts.

Table 7.2 summarises the main characteristics of financing schemes according to the above criteria. Figure 7.2 presents a "criteria-tree" showing how the combination of these criteria defines the main categories of health care financing schemes. The "criteria-tree" provides a precise algorithm to help experts categorise the components of a country's health financing system.

The classification of financing schemes also fulfils the key statistical requirements of classifications, i.e. that the categories are mutually exclusive.

The label of HF.1.2.1 and the criteria tree contain some simplifications: the label HF.1.2.1 *Social health insurance schemes* does not show that Social health insurance schemes does include those social security programmes in which the payment for health services is complementary to the main types of benefits, such as pension and unemployment benefits. These social security schemes are not labelled as health insurance in the national practice of the countries concerned (for more detail, see the section on HF.1.2.1).

To facilitate the definition of a financing scheme, the criteria and the decision tree linked to them are presented below. The logic of this tree is to comply with a very relevant rule: each scheme can be classified only once. The classificatory criteria should be as clear as possible so that each scheme can be classified in only one position.

Table 7.2. **Main criteria of health care financing schemes**

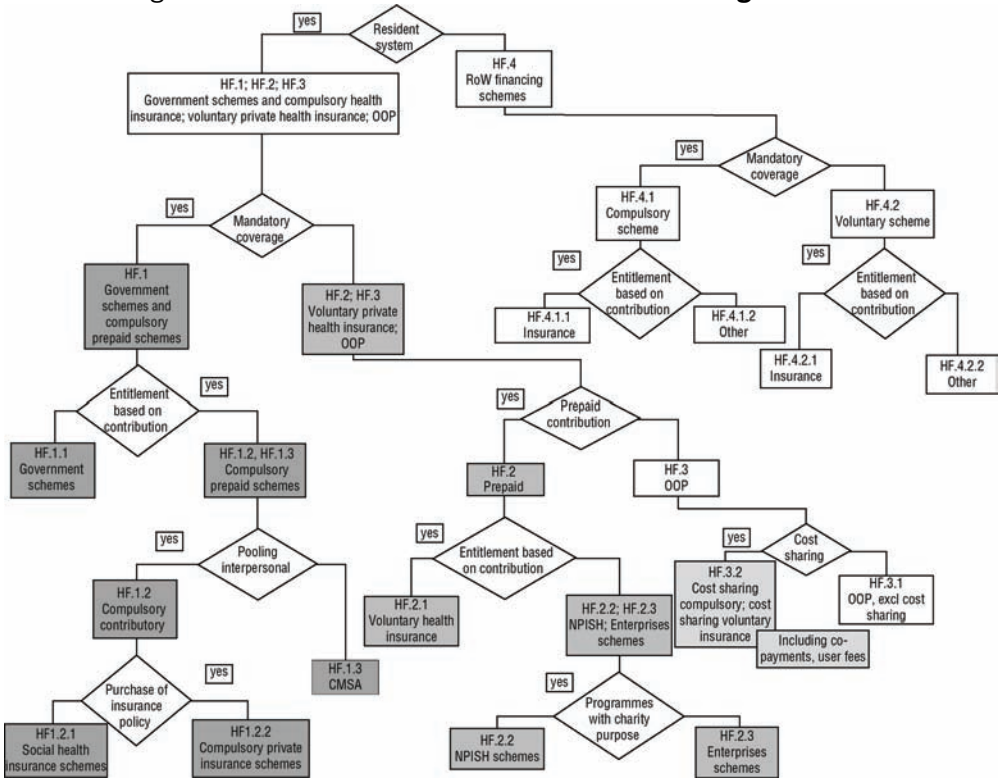
	Mode of participation	Benefit entitlement	Basic method for fund-raising	Pooling
HF.1.1. Government schemes	Automatic: for all citizens/ residents; or a specific group of the population (*e.g.* the poor) defined by law/government regulation.	Non-contributory, typically universal or available for a specific population group or disease category defined by law (*e.g.* TB, HIV, oncology).	Compulsory: budget revenues (primarily taxes).	National, sub-national, or programme 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 taken 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 the 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-equalisation 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-equalisation 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 (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 non-income-related premium (often directly or indirectly risk-related). Government may directly or indirectly (*e.g.* tax credits) subsidise.	Scheme level
HF.2.2 Non-profit institutions 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: household 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: IHAT for SHA 2011.

- The initial question is whether the scheme is based in the country or abroad. The rest of the world financing schemes refer to schemes set abroad (generated and regulated abroad). Resident schemes are classified regardless of the origin of their resources.
- For both cases, resident and foreign (rest of the world schemes), the next classificatory criterion is based on the mode of participation. Notably the compulsory coverage is related to government schemes and compulsory pre-paid schemes. Their further classification is based on whether the characteristics of the benefit entitlement are based on contributions.

The voluntary inclusion is classified based on the prepayment and its coverage, *i.e.* linked to contributions, and to cost-sharing.

Figure 7.2. **Criteria tree for health care financing schemes**



Source: IHAT for SHA 2011.

Definition of health care financing schemes[11]

> Health care financing schemes are structural components of health care financing systems: they are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Third party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health services and the rules on raising and then pooling the revenues of the given scheme.

Table 7.3 shows the full HF classification.[12]

Table 7.3. **Classification of health care financing schemes**

Code	Description
HF.1	**Government schemes and compulsory contributory health care financing schemes**
HF.1.1	**Government schemes**
HF.1.1.1	Central government schemes
HF.1.1.2	State/regional/local government 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 enterprises 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	**NPISH financing schemes**
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)
HF.2.2.2	Resident foreign government development agencies schemes
HF.2.3	**Enterprise financing schemes**
HF.2.3.1	Enterprises (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**[13]
HF.3.2	**Cost sharing with third-party payers**
HF.3.2.1	Cost sharing with government 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 NGOs schemes
HF.4.2.2.2	Foreign development agencies 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	NPISH
HF.RI.1.5	Rest of the world
Financing schemes and the related cost-sharing together	
HF.RI.2	Government 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)

Source: IHAT for SHA 2011.

The definition of health care financing schemes calls for further clarification. In correspondence with the ESSPROS, the body of rules referred to in this definition may be established *de jure*, by virtue of laws, regulation or contracts, or *de facto*, by virtue of administrative practice. *De facto* schemes include, for example, occupational health programmes set up by employers.

Table 7.4 compares HF classification under SHA 2011 with that of SHA 1.0. It is emphasised again that there is a difference between SHA 2011 and SHA 1.0 concerning the concept of HF: the HF categories under SHA 2011 are types of financing schemes, while the HF categories under SHA 1.0 were a mixture of schemes (such as private social insurance) and institutional units (such as private insurance enterprises). Table 7.4 does not show the fourth-digit or memorandum items.

Table 7.4. **ICHA-HF in SHA 2011 in comparison to SHA 1.0**

ICHA-HF classification of health care financing schemes SHA 2011		ICHA-HF classification of health care financing SHA 1.0	
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**HF.1**	**General government**
HF.1.1	**Government schemes**	**HF.1.1**	**General government excluding social security funds**
HF.1.1.1	Central government schemes	HF.1.1.1	Central government
HF.1.1.2	State/regional/local government schemes	HF.1.1.2	State/provincial government
		HF.1.1.3	Local/municipal government
HF.1.2	**Compulsory contributory health insurance schemes**		
HF.1.2.1	Social health insurance	**HF.1.2**	Social security funds
HF.1.2.2	Compulsory private insurance		
HF.1.3	**Compulsory Medical Saving Accounts**		
		HF.2	**Private sector**
HF.2	**Voluntary health care payment schemes (other than OOP)**		
HF.2.1	**Voluntary health insurance schemes**		
HF.2.1.1	Primary/substitutory health insurance schemes	HF.2.1	Private social insurance
HF.2.1.2	Complementary/supplementary voluntary insurance schemes	HF.2.2	Private insurance enterprises (other than social insurance)
HF.2.2	**NPISH financing schemes**	HF.2.4	NPISH (other than social insurance)
HF.2.3	**Enterprise financing schemes**	HF.2.5	Corporations (other than health insurance)
HF.2.3.1	Enterprises (except health care providers) financing schemes		
HF.2.3.2	Health care providers financing schemes		
HF.3	**Household out-of-pocket payment**	HF.2.3	Private household out-of-pocket expenditure
HF.3.1	Out-of-pocket excluding cost-sharing	HF.2.3.1	Out-of-pocket excluding cost-sharing
HF.3.2	Cost sharing with third-party payers:	HF.2.3.2	Cost sharing: central government
HF.3.2.1	Cost sharing with government schemes and compulsory contributory health insurance	HF.2.3.3	Cost sharing: state/provincial government
		HF.2.3.4	Cost sharing: local/municipal government
HF.3.2.2	Cost sharing with voluntary insurance schemes	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.4	**Rest of the world financing schemes**	**HF.3**	**Rest of the world**
HF.4.1	Compulsory schemes (non-resident)		
HF.4.1.1	Compulsory health insurance schemes (non-resident)		
HF.4.1.2	Other schemes (non-resident)		
HF.4.2	Voluntary private schemes (non-resident)		
HF.4.2.1	Voluntary health insurance schemes (non-resident)		
HF.4.2.2	Other schemes (non-resident)		

Source: IHAT for SHA 2011.

Explanatory notes to the ICHA-HF classification of health care financing schemes

HF.1 Government schemes and compulsory contributory health care financing schemes

This category includes all schemes aimed at ensuring access to basic health care for the whole society, a large part of it, or at least some vulnerable groups. Included are:

government schemes, social health insurance, compulsory private insurance and compulsory medical saving accounts.

A key rationale for government intervention in health systems is to ensure access to basic health care for the whole society (or vulnerable social groups). This purpose can be pursued through different coverage schemes, which implies differing levels of redistribution between social groups and individuals. Health accounts are also expected to provide information for assessing how well health systems achieve this key policy goal. Therefore, for international comparability, it is important to have a general, aggregate category that includes all financing schemes that serve this goal.

HF.1.1 Government (health care financing) schemes

The characteristics of government health care financing schemes are determined by law or by the government. A separate budget is set for the programme, and a government unit has an overall responsibility for it. Usually, but not necessarily, government schemes are operated by government unit(s). The government schemes may also be managed by NPISH or by an enterprise.

Government (health care financing) schemes have the following characteristics:

- Mode of participation: automatic for all citizens/residents, or for a specific group of the population (*e.g.* the poor) defined by law/government regulation;
- Benefit entitlement: non-contributory, typically universal or available for a specific population group or disease category defined by law (*e.g.* TB, HIV, oncology);
- Basic method for fund-raising: compulsory; domestic revenues of government (primarily taxes). Foreign revenues may also play an important role in some lower-income countries.
- Mechanism and extent of pooling funds: national, sub-national, or programme level.

A government scheme does not necessarily cover the total price of the services and goods included in its benefit basket, that is, the scheme may involve cost-sharing with the patients through co-payments, or other forms of cost-sharing). The full costs of certain services are shared between two financing schemes: the government scheme and the OOP (cost-sharing). (The same holds true for the compulsory insurance and voluntary insurance schemes.) Obviously, only the costs covered by the government scheme are accounted under HF.1.1. As the full cost of these services also constitutes important information, the following memorandum items are included in the classification: government 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.2.1 + HF.3.2.2).

Country examples

Government health care financing schemes were the major financing schemes in fifteen OECD countries in 2009 (for example, Canada, Denmark, New Zealand, Spain, United Kingdom and so on), accounting for 55-85% of total health expenditure in these countries. These OECD health systems are primarily financed from the state budget (for example, the National Health Service of the United Kingdom), or under the responsibility of the local/regional governments in the Scandinavian countries). The universal entitlement of the population (or groups of the population) for a fairly comprehensive benefit package is defined by law.

Government financing schemes can take many forms. Some examples include:

- General government financing programmes that provide primary health coverage for the entire population, as in the OECD examples noted above, as well as where such programmes meet the same core criteria (*i.e.* universal non-contributory entitlement) but may cover far less than half of total health spending (in many low-income countries, for example);
- Programmes for specific groups of the population (for example, Medicaid in the United States, the Civil Servants Medical Benefits Scheme in Thailand, etc.);
- General government financing programmes in specific areas of the health sector, for example, public health, some aspects of prevention, investments, research, education, the HIV programme, the TB programme, etc.;
- Government expenditure on administration of the health system;
- Subsidies paid by the government *to health care providers* to cover persistent losses (included in health care expenditure) are classified in category HF.1.1;
- Health-specific conditional cash transfers to households.[14]

Government schemes that offer universal *entitlement* may still demand individual enrolment. For example, in Thailand *the Universal Coverage Scheme* (UCS), which covers 74.6% of the population and is financed solely from general tax revenue, is a government scheme with universal entitlement. To access health services under the UCS, entitled persons need to register at a public hospital responsible for managing the programme. Enrolment is not obligatory, and anyone still uninsured can register at any time.

Government schemes can involve a purchaser-provider split, and sometimes the names of schemes can be misleading. For example, in Latvia, the "State Compulsory Health Insurance Fund" is funded entirely by general budget transfers and provides coverage to all Latvian citizens on a non-contributory basis. It is thus a "government scheme", and not a social insurance scheme, despite the name of the government agency.

One specific accounting issue is the treatment of capital charges. In some countries – in an effort to increase efficiency – public hospitals may be required to pay charges to the government for the use of the physical assets. Although the payment of capital charges is a cost component of the hospital, and as such should be recorded together with the other factors of provisions (Chapter 9), it may be the case that capital charges are deducted directly out of the budget the hospitals receive from the state budget. In such circumstances, the capital charges should be added to the payment made by the government to the hospital in order to record the total expenditure of the government schemes.

Sub-categories of government schemes

Sub-categories of government schemes are:

- Central government schemes (HF.1.1.1);
- Regional/local government schemes (HF.1.1.2).

Countries may want to distinguish the regional and local level of government for national data reporting purposes. In this case, they can create relevant sub-categories under the "regional/local government schemes".

Countries may want to create further optional sub-categories, for example, by types of government programmes.

Government employees schemes

Government (or public) employees may have a separate arrangement: government may provide specific health programmes for its employees or buy private insurance. In some countries, the government reimburses its employees' health care bills and pays for their care while abroad. Optional sub-categories under government schemes can be used to account for these cases, as follows:

- HF.1.1.1.1 Central government schemes (excluding government employees schemes);
- HF.1.1.1.2 Government employees schemes.

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

It is not necessary to distinguish between government (or public) employees and other insurees in the case where government employees participate in the general social insurance scheme and the government pays a social insurance contribution in the same way that other employers do.

HF.1.2 Compulsory contributory health insurance schemes

Compulsory health insurance involves a financing arrangement to ensure access to health care for specific population groups through mandatory participation and eligibility based on the payment of health insurance contributions by or on behalf of the individuals concerned.

HF.1.2.1 Social health insurance schemes. Social health insurance is a financing arrangement that ensures access to health care based on a payment of a non-risk-related contribution by or on behalf of the eligible person. The social health insurance scheme is established by a specific public law, defining, among others, the eligibility, benefit package and rules for the contribution payment.

Social health insurance schemes have the following characteristics:

- *Mode of participation*: mandatory, either for all citizens/residents or for a specific population group defined by law/government regulations (*e.g.* formal sector employees);
- *Benefit entitlement*: contributory, based on non-risk-related payments made by or on behalf of the insured person. Family members may or may not be covered on the basis of the contributor's payment. The government may make contributions on behalf of certain defined categories of the population (*e.g.* pensioners).
- *Basic method for fund-raising*: compulsory non-risk-related health insurance contributions. Insurance contributions may be paid by the government (from the state budget) on behalf of some non-contributing groups of the population, and the government may also provide general subsidies to the scheme.
- *Mechanism and extent of pooling funds*: national, sub-national, or by scheme. With multiple funds, the extent of pooling will depend on risk-equalisation mechanisms across schemes. By using such mechanisms, it is possible to create pooling across schemes.

Traditionally, laws on social health insurance define the coverage of persons and the benefit basket to which the insured persons are entitled. Usually (but not necessarily) those who are entitled are also mandated. Entitlement for services originates from the law on social health insurance, which establishes the insurance automatically for all persons who meet the criteria. With some exceptions (*e.g.* non-residents), no individual contract

between the insurance fund and the insured is involved on the basis of their contributions (including made on their behalf).[15] Membership may be legally assigned, usually based on two criteria: 1) professional status or employer; and 2) place of residence. In some countries insurees may have the right to choose an insurance fund.

One main characteristic of social insurance schemes is that contributions are not related to risk. Contributions are raised mainly through wage-related (and occasionally income-related) contributions that are shared between employers and employees. There are differences between countries with respect to: the uniformity of the rate; the ratio of employer contributions to employee contributions; the existence of an upper contribution ceiling; the existence of additional non-wage-related revenues; the calculation of contributions for non-waged persons; and the role of general government revenues in funding.

This category includes *all* social insurance schemes that provide health care services, even if their main activity is not health-related (*e.g.* some pension schemes would fall into this category). Of course, only the health-related spending of these schemes is reported under HF.1.2.1.

Country examples

Social health insurance schemes have been established in more than 60 countries all over the world (Gottret and Schieber, 2006). Social health insurance was the major financing scheme in thirteen OECD countries in 2009 (including Austria, France, Germany, Japan, Korea and the Slovak Republic). Social health insurance schemes exist in many other countries as well, though often with limited population coverage.

In some countries the law defines the entitled groups, but it is not mandatory for the eligible persons to enrol in the programme. An example is Medicare in the United States: it is mandatory to pay payroll taxes for Medicare, and every person aged 65 and over is entitled to enrol in Medicare, but enrolment is not compulsory.

In many countries with social health insurance schemes, the central budget pays a contribution on behalf of certain population groups (such as people without an income, children, etc.). For example, in Moldova the contribution made by or on behalf of covered persons is the basis of entitlement. In 2008, the central budget transfers to the National Health Insurance Company accounted for 55% of its revenues, while the payroll tax provided only 42%. Even though most of its revenues come from general government budget transfers, this is clearly a social health insurance scheme, because the basis for entitlement is contributory (the transfers are on behalf of specific individuals/groups of the population, while other groups are not covered).

The criteria provided in Table 7.2 and Figure 7.2 make clear how to categorise a financing scheme in an internationally comparable way, even when the names of the relevant agencies may be potentially confusing. The example of Latvia was shown above to be a government financing scheme, even though the name of the Financing Agent is the State Compulsory Health Insurance Agency. The mode of participation is universal, *i.e.* based on citizenship, and entitlement is non-contributory. In Estonia, conversely, the main revenue sources for the Estonian health insurance fund (EHIF) are social insurance contributions from employers and employees (called the "social tax" in Estonia). However, the government must approve the budget for the EHIF as part of its responsibility to keep the overall fiscal deficit within the Maastricht criteria. Despite this government

involvement, the EHIF should be classified as a social health insurance scheme, because entitlement to benefits is determined on a contributory basis (paid by or on behalf of the insured persons).

Government may contribute to social health insurance schemes in its role as an employer. For example, in Tanzania, public service employees have to participate in the National health insurance fund, with a contribution of 3% of member's salaries made by the government as the employer and an equal 3% made by the employee.

In China, there are now three major schemes: i) the Urban employees' basic medical insurance scheme (UEBMI); ii) the New rural co-operative medical scheme (NRCMS) for the rural population; and iii) the Urban basic health insurance scheme (UBHI), covering elementary and middle school pupils, teenagers and young children, the elderly, the disabled and other nonworking urban residents. Under the UEBMI, employers and employees each pay a share of the premium, and enrolment is mandatory. For the NRCMS and the UBHI, participation is voluntary, with the government subsidising a substantial part of the premiums (80% at the end of the 2000s). Thus, only the first of these – the UEBMI – should be classified as social health insurance. Because their mode of participation is voluntary, the other two should be classified as voluntary health insurance (VHI) schemes, despite the substantial level of public subsidies. The ICHA-HF classification makes it possible to distinguish such schemes as a specific type of voluntary health insurance (HF.2.1.1.2 Government-based voluntary health insurance).

There are examples where the same agency manages different schemes. In Kyrgyzstan, for example, the same public agency (the Mandatory Health Insurance Fund, or MHIF) is the financing agent for both a "government scheme" and a "social health insurance" scheme. The MHIF manages a universal, population-based entitlement funded from general revenues, as well as a contributory-based entitlement funded from a mix of payroll tax and general budget transfers. The contributory social health insurance scheme is explicitly complementary to the non-contributory government scheme. In Slovenia, the compulsory health insurance fund (the Health Insurance Institute of Slovenia, HIIS) also sells complementary voluntary health insurance, which is in competition with insurance offered by private companies. Thus, the HIIS manages the social health insurance scheme and one of the voluntary health insurance schemes in the country.

HF.1.2.2 Compulsory private insurance schemes. Compulsory private insurance is a financing arrangement under which all residents (or a large group of the population) are obliged to take out health insurance with a health insurance company or health insurance fund, meaning that the purchase of private coverage is mandatory. The insurance is established by (*i.e.* entitlement for services is based on) an insurance contract/ agreement between the individual and the insurer.

Compulsory private insurance schemes have the following characteristics:

- Mode of participation: mandatory, either for all citizens/residents, or for a specific group of the population obligated by law/government regulation to purchase a health insurance policy (*e.g.* formal sector employees);
- Benefit entitlement: contributory, based upon the purchase of an insurance policy from a selected health insurance company (or other agency involved);
- Basic method for fund-raising: compulsory health insurance premiums, sometimes partially or fully subsidised by the government, including the possible use of tax credits;[16]

- Mechanism and extent of pooling funds: national, sub-national, or by scheme; with multiple funds, the extent of pooling will depend on risk-equalisation mechanisms across schemes. This also depends on the extent of regulation of the premium and the standardisation of benefits across schemes.

Country examples

In the Dutch system introduced from 1 January 2006, the government heavily regulates the market for compulsory insurance: insurers are obliged to accept anybody for the basic package of services, and the insurance premium is unrelated to individual risks. At the same time, the day-to-day operation of health insurance is now organised under private law (Netherlands Ministry of Health, Welfare and Sport, 2005). Entitlement for services is based upon a contract between the individual and the selected health insurance company. Anyone who fails to fulfil the obligation to buy insurance becomes uninsured, and insurers are allowed to remove the non-payers from their list. The number of uninsured was estimated at around 1.7% of the population in 2009 (CBS, Statline, updated 31/08/2010).

Notes

In countries where insurance companies are financing agents for compulsory insurance, insurance companies, at the same time, also offer voluntary, complementary insurance. In this case, an insurance company acts as a financing agent for two different financing schemes. These schemes operate under different regulations.

HF.1.3 Compulsory medical savings accounts

Compulsory Medical Savings Accounts (CMSAs) have the following characteristics:

- Mode of participation: mandatory for all citizens/residents, or for a specific group of the population defined by law/government regulation;
- Benefit entitlement: contributory based upon the purchase of MSAs, persons having MSAs can, however, use only the money saved, regardless of whether the saving covers the costs of the care necessary;
- Basic method for fund-raising: compulsory, defined by law (*e.g.* as percent share of income);
- Mechanism and extent of pooling funds: no pooling across individuals, except perhaps family members.[17]

Under compulsory MSAs, it is legally compulsory to take out a medical savings account; and the minimum payments and some issues concerning the use of the accounts to pay for health services are regulated by the government. Its compulsory feature justifies categorising it under HF.1.

Although CMSAs are a form of compulsory prepayment, the absence of inter-personal pooling means that they should not be considered a sub-category of compulsory insurance. The compulsory nature of the CMSA makes it different from other types of people's savings, including the non-compulsory MSAs found in some countries, such as China and the United States. Where MSAs are voluntary, they are essentially indistinguishable as a "scheme" from other types of out-of-pocket spending (under HF.3), since the "source" of funds for such spending is household savings (or borrowing), whether or not this is from something designated as a "health" or "medical" savings account.

Country example

In 1984, Singapore introduced a system of medical savings accounts, called Medisave, and it is currently the only country in the world with CMSAs. Every employed citizen is obliged to pay 6-8% of their income – according to age – into an individual account managed by the state. Savings in the individual medical savings accounts can be used to pay for hospital costs and certain selected outpatient costs for a state-approved catalogue of services (Gottret and Schieber, 2006).

HF.2 Voluntary health care payment schemes (other than Household out-of-pocket payments)

This category includes all domestic pre-paid health care financing schemes[18] under which the access to health services is at the discretion of private actors (though this "discretion" can and often is influenced by government laws and regulations). Included are: voluntary health insurance, NPISH financing schemes and Enterprise financing schemes.

The term "compulsory scheme" refers to schemes where membership is made compulsory by the government (by law). All other schemes are considered voluntary. For instance, an employer can decide to have a group insurance for all its employees: this is considered as voluntary insurance, although for each employee participation in the insurance can be imposed by the employer.

There is one important difference between these schemes and household OOP payments that is of critical policy-relevance: the presence or absence of inter-personal and/or inter-temporal pooling, which is also reflected in the separation between the time of payment and the time of service use. In the case of OOP payments, households must pay the whole or part of the cost of care at the time of care delivery. OOP expenditures show the *direct* financial burden of medical care for the household, which may have a catastrophic effect on its financial situation. This justifies a separate first-digit level category for voluntary private schemes (other than OOPs) and Out-of-pocket payments.[19]

HF.2.1 Voluntary health insurance schemes

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);
- Mechanism and extent of pooling funds: individual scheme level.

Voluntary health insurance is taken up and paid for at the discretion of individuals or firms. Voluntary health insurance may also be purchased by the employer.

Premiums may be either risk-rated or community-rated, but in some countries (*e.g.* France) even income-related. Voluntary insurance is usually purchased from private insurance organisations (both for-profit and non-profit), although in some cases it may also be purchased from public or quasi-public bodies. In several countries enterprises may also have their own insurance arrangements.

Sub-categories of voluntary health insurance

There are several possible aspects that distinguish different types of voluntary health insurance. These aspects may overlap or may be combined when creating sub-categories of voluntary health insurance. For example, both group policies and individual policies can provide either primary or complementary coverage. The type of coverage, that is, whether the voluntary insurance provides primary coverage or complementary coverage for an individual, is the most important factor for defining the sub-categories.

HF.2.1.1 Primary/substitutive insurance schemes . Voluntary health insurance is labelled primary coverage or "substitutive" if it covers people who are excluded from or allowed to opt out of the public system, and who are not mandated to buy private health insurance, or simply if there is no publicly mandated system available to them (as for much of the population under age 65 in the United States, for example). It is important to distinguish voluntary substitutive insurance from systems where at least some people are given the choice to either join the social health insurance or buy private insurance, but are obliged to buy some form of health insurance. In Germany until 2009, higher-income persons were allowed to "opt out" of the statutory insurance arrangement and did not have to obtain any health insurance. Since 2009, health insurance has been obligatory, and opting out is hampered by new rules on income measurement. Furthermore, a privately insured person can return to social healthcare insurance only if that person is required by legislation to hold social healthcare insurance (*e.g.* if that person's income decreases under certain conditions).

HF.2.1.1.1 Employer-based insurance . One main type of group insurance is insurance purchased by employers, through a contract between the employer (the company) and the insurance entity. The premium paid by the employer is usually risk-related at the group level, but the contributions paid by the individuals are usually not risk-related.

HF.2.1.1.2 Government-based voluntary insurance . This specific type of insurance scheme is initiated and subsidised by the government in order to provide primary coverage for specific groups of the population. Such schemes may be initiated, for example, when the government does not have the administrative capacity necessary for running a compulsory insurance. For example, in China the government has set up, operates and heavily subsidises the New rural co-operative medical scheme (NRCMS) for the rural population, and the Urban basic health insurance scheme (UBHI), which covers elementary and middle school pupils, teenagers and young children, the elderly, the disabled and other nonworking urban residents.

HF.2.1.1.3 Other primary coverage schemes . This category includes primary coverage insurance taken by individuals or group insurance other than HF.2.1.1.1 and HF.2.1.1.2. For example, insurance companies can offer group insurance to patient organisations and the like.

HF.2.1.2 Complementary or supplementary voluntary insurance schemes . Health insurance can be complementary in two ways: it can cover services excluded from the public system or it can cover cost-sharing obligations (i.*e.* user charges, co-payments, etc.) required by the compulsory insurance or government health scheme. Supplementary health insurance covers the same services as the compulsory insurance, but ensures faster access and/or enhanced consumer choice of providers (Thomson and Mossialos, 2009).

Complementary and supplementary VHI can exist in the same scheme, as in Ireland, where the combined scheme covers about 50% of the population. High levels of complementary VHI have been attained in Slovenia and France, where it covers over 70% and 92% of the population, respectively, to reimburse the costs of statutory user charges (*ibid*.). Examples of supplementary VHI include private insurance in countries such as the United Kingdom and Spain.

Complementary VHI that reimburses cost-sharing by the patient can create an accounting challenge. This case should be treated similarly to cases where voluntary insurance reimburses the bill for a service not covered by compulsory insurance. The payment is considered 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 a proper attribution of health expenditures.

HF.2.1.2.1 Community-based voluntary health insurance . Community-based voluntary health insurance implicitly provides complementary or supplementary coverage in some lower- and middle-income countries, often in contexts where the individuals are legally entitled to the services of government health schemes, but where such schemes are not fully effective. Key characteristics of community-based health insurance include:

- Mode of participation: voluntary;
- Benefit entitlement: based upon contribution;
- Basic method for fund-raising: defined at local level;
- Mechanism and extent of pooling funds: at scheme level, often described as being "local community" level. While schemes may operate on a local community level, some may not be geographic in nature but instead be organised on another basis (*e.g.* the health insurance scheme of the Self-Employed Women's Association of India)

Community-based health insurance is a form (subcategory) of voluntary health insurance that exists in many low- and middle-income countries, especially in Africa and Asia (Carrin, 2003; ILO, 2005). "These schemes exist within localised communities, most often in rural areas: members make small payments to the scheme, often annually and after harvest time, and the scheme covers the fees charged by local health services." (McIntyre, 2007, p. 4)

Most community-based health insurance schemes in Sub-Saharan Africa are based on the voluntary participation of individuals and have fewer than 500 members. The population covered by these schemes is still relatively small in most low-income countries (Gottret and Schieber, 2006).

Community-based voluntary health insurance may be subsidised by the central government, as is currently the case in Rwanda.

HF.2.1.2.2 Other complementary or supplementary schemes . This includes complementary or supplementary schemes other than HF.2.1.2.1. It is possible to split this category according to the characteristics of insurance premium, such as Other complementary voluntary insurance: risk-rated premiums (HF.2.1.2.2) and Other complementary voluntary insurance: non-risk-rated premiums (HF.2.1.2.3). Such schemes may be employment/group-based or individually based.

Voluntary insurance offered by the government as an employer to its employees (civil servants) should be included here. [Note: It should be distinct from government employees schemes (HF.1.1.1.2.)].

HF.2.2 Non-profit institutions financing schemes

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;
- Mechanism and extent of pooling funds: varies across programmes but typically programme-level.

This category is proposed as a replacement for SHA 1.0 item "HF.2.4. Non-profit institutions serving households (other than social insurance)". The category of non-profit institutions has proved rather ambiguous during SHA implementation. The definition in SHA 1.0 was taken from SNA 1993: "Non-profit institutions serving households (NPISH) consist of non-profit institutions which provide goods or services to households free or at prices that are not economically significant." This definition does not allow for a clear distinction between non-profit institutions as third-party payers of health care and non-profit institutions as providers of care. For example, hospitals may have a non-profit legal status and provide services to households free of charge under a social insurance scheme, in which case, of course, the social insurance is the financing scheme and the hospital (HP.1) is the provider. The unambiguous way in which the ICHA-HF interprets financing schemes provides a starting point.

A qualitative analysis of an NGO's activity is always required in order to decide whether the given activity can be regarded as the operation of a financing scheme. A few examples are given for the different NPISH functions.

- An NPISH organisation may provide – besides their non-health activity – resources for other NPISH that carry out the financing of special health programmes. The NPISH in question does not have a direct relationship with providers of care. In this case NPISH is a provider of resources and the programme of the NPISH is the financing scheme.
- A non-profit institution may create a special fund, usually through donations to finance special types of health services, for example, to operate special facilities for the homeless, or to provide 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 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.
- The "non-profit" institution may be the legal form through which providers receive payment, for example, from a social health insurance scheme as compensation for the services they provide. In this case the NPISH is a provider and the social health insurance is the financing scheme.

HF.2.3 Enterprise financing schemes

This category primarily includes arrangements where enterprises directly provide or finance 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.

Enterprise financing schemes have the following characteristics:

- Mode of participation: voluntary choice of particular enterprise/corporation, with coverage based on employment at the 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;
- Basic method for fund-raising: voluntary choice of the firm to use its revenues for this purpose;
- Mechanism and extent of pooling funds: at an individual enterprise level.

Compared to SHA 1.0, the change is in the label (and hence the definition) so that it better reflects the content of the data. The label in the SHA 1.0 Manual is: "Corporations (other than health insurance)". This label is not accurate, as corporations may provide revenues to other financing schemes, for example, they may pay insurance contributions or voluntary insurance premiums. The revised category better reflects the actual role of the enterprises accounted under this category (as financing schemes).

A distinction between two sub-categories is proposed: enterprise financing schemes (except health care providers); and Health care providers..

Under the special category of Health care providers financing schemes (HF.2.3.2) health care providers finance part of the services they provide to their patients from their own sources (that are additional sources to the payment they receive from the financing schemes). These are "imputed" expenditures included in health accounts in order to obtain an adequate estimation of the value of the services consumed by individuals. In fact, payments are made for the factors of health care provision by the providers or suppliers of these factors (*e.g.* pharmaceuticals), as the payment by the purchasers does not cover the full costs of providing the services concerned. For an adequate estimate of the value of the services concerned, these specific items are estimated and accounted as expenditure by Health care providers financing schemes (HF.2.3.2), and the revenues are accounted as FS. 6.2. Other revenues from corporations *n.e.c.* These specific sources may be as follows:

- Health care providers may have special revenues from economic activities other than the provision of health services (for example, lending premises, providing laundry or catering services for other institutions, or private hospitals may have revenues from interest, etc.) and they may use these revenues to cover the costs of health services they provide.
- A private hospital may incur a loss in one year. To balance revenues and expenditure, the hospital may take out a loan from a commercial bank to be repaid in subsequent periods.
- In some countries, a public hospital may accumulate arrears (unpaid bills) towards suppliers of pharmaceuticals (or other material resources). The increase in these arrears in the given accounting period can, in fact, be interpreted as additional financing raised by the provider,

Country examples

Occupational health services in several countries (*e.g.* in Hungary) are excluded from the benefit package of social health insurance, and employers are obliged to finance occupational health examinations specified by law.

HF.3 Household out-of-pocket payment

Households' out-of-pocket expenditure by definition is regarded as a financing scheme. Its distinguishing characteristic is that it is a direct payment for services from the household primary income[20] or savings (no third-party payer is involved): the payment is made by the user at the time of the use of services. Included are cost-sharing and informal payments (both in cash and kind).

Out-of-pocket payments (OOP) show the direct burden of medical costs that households bear at the time of service use. (This is the reason for categorising OOP as a first-digit level category of ICHA-HF.) OOP play an important role in every health care system. In lower-income countries, out-of-pocket expenditure is often the main form of health care financing.

OOP expenditure (schemes) is characterised by:

- Mode of participation: voluntary, based on the willingness and ability to pay of the individual or household, though the government or voluntary insurance scheme may specify the amount of payment that is required;
- Benefit entitlement: contributory: the service is provided if the individual pays;
- Basic method for fund-raising: voluntary, based on the decision of the household to use the services, and therefore to pay for them.[21] The government may indirectly subsidise some OOP expenditures through tax deductions or credits;
- Mechanism and extent of pooling funds: no inter-personal pooling.

From a health policy perspective, it is important to distinguish *three main types of out-of-pocket expenditure* (OOP): OOP excluding cost-sharing (HF.3.1); OOP cost-sharing with government schemes and compulsory contributory health insurance schemes (HF.3.2.1); and OOP cost-sharing with voluntary insurance schemes (HF.3.2.2). The role (share) of each of these sub-categories and the changes in the share over time provide a more detailed picture of the burden of health financing on households than does just total OOP. Furthermore, the three types may provide important information about the effect of government intervention in health financing.

Informal payments are considered as out-of-pocket-payments and reported under HF.3.1. Note: only formal cost-sharing is reported under HF.3.2 (Cost sharing with third-party payers).

Notes

A payment by the individual is not always accounted as OOP, because it may be reimbursed by voluntary insurance or covered by the government (conditional cash transfers) or a domestic or foreign NGO. In these cases, the payment for the health care is technically made by the household, but not from the household's "pocket", *i.e.* not from the household's primary income or savings. Therefore, the first step is to deduct those items that should be accounted as other than OOP, such as government schemes (conditional cash allowances), voluntary insurance, NPISH financing schemes and RoW financing

schemes. Also tax credits and income tax deductions generated by health spending should be taken into account when estimating OOP.

The only possible sources of OOP are the household's income (including remittances) or savings or loans that it has taken out. (Chapter 8 provides a table for distinguishing OOP from payments made by households but not accounted as out-of-pocket payment.)

The payments from Voluntary Medical Saving Accounts for health care services or goods in the given accounting period are regarded as a special type of out-of-pocket payment, but not accounted separately from OOP. *Note*: The payments into Voluntary Medical Saving Accounts in the given accounting period are not included in the HF tables, as they are not payments for health care services or goods.

Households as an institutional sector are defined as the financing agent for household out-of-pocket payments.

It is important to distinguish households as an institutional sector and household OOP as a financing scheme. Households, as an institutional sector, play several roles in the health system: as beneficiaries, as providers of sources to third-party financing schemes (by paying taxes and/or insurance contributions and/or insurance premiums); as informal providers of care; and last but not least, as a financing agent for OOP.

The special case of household cost-sharing covered by voluntary insurance has been discussed above under complementary voluntary health insurance.

HF.4 Rest of the world financing schemes

This item comprises financial arrangements involving institutional units (or managed by institutional units) that are resident abroad, but who collect, pool resources and purchase health care goods and services on behalf of residents, without transiting their funds through a resident scheme. For example, a person resident in country A can buy a voluntary insurance in country B and can use that insurance to pay for services in either Country A or B. US citizens of Mexican origin, for instance, may buy health insurance in Mexico that gives them emergency cover in the United States but pays for elective treatment in Mexico.

A resident scheme has the predominant economic interest in the country for which the accounts are drawn up. It has a physical presence in the country and is under the jurisdiction of the local government (*e.g.* compulsory reporting activities). Non-resident (RoW) schemes may also operate in the country for which the health accounts are produced, but these schemes originate with and are controlled by agencies subject to foreign government jurisdiction, including, for example, aid agencies and military agencies.

Rest of the world financing arrangements are defined according to the following characteristics:

- Mode of participation: 1) mandatory, *e.g.* based on the conditions of employment (such as foreign insurance), or 2) voluntary;
- Basis for entitlement: 1) a contract between an insurance carrier and the individual, or 2) discretion of a private entity (charity foundation, employer, foreign entity);
- Method for fund raising: funds are collected and pooled abroad;
- Coverage: foreign entities usually have the freedom to design the benefits.

Note that the rest of the world usually contributes to the financing of health care in the example of a typical model economy, as international aid and other flows, by channelling the funds via government or resident NPISH agencies. This is a typical case of RoW revenue for resident financing schemes, and could thus be classified as HF.1 or HF.2 spending and RoW revenue.

International agreements strive to ensure that external funding agencies work with resident health care agencies to ensure that external resources (financing revenues) are directed towards national priorities in a co-ordinated way. There is a need for reporting to national authorities and co-ordinating with national efforts to achieve that goal and foster complementary health actions. Agencies managing external funds for aid would then be acting as residents (resident units and schemes). If SHA adjusts for international aid agreements, the external resources would be recorded as external sources (revenues) and would in most cases be executed by resident schemes, grouped as NGOs and corporations.

It is not always clear whether a foreign assistance programme should be accounted as *i)* a financing RoW source (FS), or *ii)* both as a financing RoW source and a financing RoW scheme.

In the case of enclaves, these are non-resident units that are physically located in the host territory but have immunity from the host country laws (*e.g.* international organisations and embassies). When health care for the personnel of enclaves does not require any allowance or jurisdiction of the resident country, then the foreign health scheme should be classified as a RoW financing scheme (HF.4). However, an entity created by a government under the laws of another jurisdiction is a resident unit in the host jurisdiction, and not part of the general government sector in either economy (SNA 2008, 26.43). Thus, a foreign aid programme set up by an external aid organisation to handle resources in a foreign country is to be considered as a resident NGO or corporation in that country.

Foreign assistance may be given for a specific purpose (*e.g.* an AIDS programme), and a separate organisation, also part of the foreign entity, may be established to manage the fund, which is not necessarily involved in the provision of the service.

When the scheme is part of a global or multinational entity but is operated in the country as a "branch", it is considered resident, *e.g.* an insurance agency having a local setting is resident. The key feature is that it shares permanent economic interests with local entities, as well as a physical presence; individual accounting and linkages to the rules of local governments, such as reporting, are also features of resident schemes.

However, when the scheme cannot be differentiated as a specific "branch" but is kept as a unique scheme because it is run as an indivisible operation with no separate accounts, then it is treated as a RoW scheme. The value of multinational schemes reported as RoW schemes cannot be taken as the entirety of multinational schemes, but would be based prorata on the volume of activity in the country.

Specific conceptual issues

The interpretation of "public" and "private"

In accounting for health financing, it is possible to calculate aggregate "public" and "private" expenditures using either the classification of financing schemes or the classification of revenues of financing schemes. In either case, there is some ambiguity

about whether to classify revenues for or expenditures by "compulsory private" schemes as public or private.[22] SHA 2011 groups them with public expenditures:

- The calculation of expenditures by financing schemes will yield the following two major expenditure aggregates:
  - Expenditure by government schemes and compulsory contributory health care financing schemes; and
  - Expenditure by voluntary health care financing schemes.
- The calculation of expenditures by the revenues of financing schemes will yield the following two major aggregates:
  - Health spending by public and compulsory private funds;
  - Health spending by voluntary funds.

Which approach is to be taken depends on the purpose of the analysis. The main distinction between the two is that in the first approach the division is performed on the level of the schemes, and follows the HF division. This approach does not account for the sources of the funds but gives information about the extent of public regulation of the healthcare system. The second approach, on the contrary, focuses on dividing the sources that feed into the financial schemes. It thus provides information about the publicly or privately regulated revenue. In other words, if the first approach answers the question, who manages the health funds, the second approach answers the question, who pays them. The second approach (public and private calculated according to the *type of revenue*) is clearly superior for meeting the objective of reporting the share of government versus non-government expenditure in the health sector. This would, for example, ensure that the large increases in spending by the Chinese government to subsidise the NCRMS, a voluntary insurance scheme, would indeed be counted as public expenditure.

Showing "compulsory private" in a separate category allows the analyst to calculate public and private shares by either including these with government spending, or not. Within the expenditure by government schemes and compulsory contributory health care financing schemes, it is possible to separate two sub-aggregates: 1) expenditure by government and social health insurance; and 2) expenditure by compulsory private schemes (see Table 7.5).

Tables 7.5 and 7.6 provide explanations for the recommended approaches and show the relevant categories.

The categories used (instead of "public" and "private") provide a more adequate picture of the structure of spending by the current complex financing arrangements.

The categories (expenditure aggregates) of "Expenditure by government schemes and compulsory contributory health care financing schemes" and "Expenditure by voluntary health care financing schemes", however, do not take into consideration that voluntary health care financing schemes may receive revenues from government. For example, total spending by NPISH financing schemes is accounted as private expenditure – although the revenue of NPISH financing schemes may partly come from government transfers. Under the other approach (Table 7.6), all spending from government general revenues on health is accounted as spending from public funds, including transfers to private financing schemes.

Table 7.5. **Expenditure by social, compulsory private and private health care financing schemes**

	Financing schemes	Major expenditure aggregates
HF.1	**Government financing schemes and compulsory contributory health care financing schemes**	**Expenditure by government schemes and compulsory contributory health care financing schemes**
HF.1.1	Government financing schemes	Expenditure by government and social health insurance
HF.1.2.1	Social health insurance	
HF.1.2.2	Compulsory private health insurance	Expenditure by compulsory private schemes – analyst can choose whether to include these as part of aggregate public or private spending
HF.1.3	**Compulsory Medical Saving Accounts (CMSA)**	
HF.2	**Voluntary health care payment schemes (other than OOP)**	
HF.2.1	Voluntary health insurance	
HF.2.2	NPISH- financing schemes	**Private expenditure**
HF.2.3	Enterprise financing schemes	
HF.3	**Household out-of-pocket payment**	
HF.4	**Rest of the world financing programmes**	

Source: IHAT for SHA 2011.

Table 7.6. **Health spending from public, compulsory private and private funds**

	Revenue of financing schemes	Major expenditure aggregates
FS.1	Transfers from government domestic revenue	**Public and compulsory private funds spent on health care**
FS.2	Transfers distributed by government from foreign origin	
FS.3	Social insurance contributions	
FS.4	Compulsory prepayment (other than FS.3)	
FS.7.1.1/FS.7.1.2	Bilateral and multilateral financial transfers	
FS.7.2.1.1/FS.7.2.1.2	Bilateral and multilateral aid in kind	
FS.7.2.2.1	Foreign aid in kind: services (technical assistance (TA) by governments and international organisations	
FS.5	Voluntary prepayment	**Voluntary private funds spent on health care**
FS.6	Other domestic revenues *n.e.c.*	
FS.7.1.3	Other foreign financial transfers	
FS.7.2.1.3	Other foreign aid in goods	
FS.7.2.2.2	Foreign aid in kind: services (including TA) by private entities	
FS.7.3	Other foreign transfers (*n.e.c.*)	

Source: IHAT for SHA 2011.

Under the above approach, the following categories are defined:

- *Public funds* include: *i)* funds allocated from general revenues of government for government schemes; *ii)* funds created from social insurance contributions; *iii)* transfers allocated from general revenues of government to health care financing schemes other than government schemes (grants, subsidies and transfers to NPISH, 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 classify them as either public or private. The decision about which approach (compulsory/public or private) is considered more appropriate will depend on the nature of the analysis to be performed;
- *Voluntary private funds*, including all other funds.

As already noted, the main difference between the two recommended approaches to the revised interpretation of "public" versus "private" expenditure is the treatment of transfers allocated from general revenues of government to health care financing schemes (other than government schemes). In order to determine total public spending on health, all government transfers including those to private entities need to be included.

Treatment of cost-sharing

There are three components of coverage by a third-party financing scheme (insurance or government scheme): population coverage, the service package covered and the share of the costs of the given services covered by the scheme. Cost-sharing by the patients should be considered as a component of out-of-pocket payment and should not be considered as expenditure by a third-party financing scheme. The concept, the monitoring and the assessment of financial protection require a clear distinction between the share of the costs covered by compulsory insurance (or a government scheme) and the share of the costs paid by the patients. Obviously, a high level of cost-sharing by the patients jeopardises financial protection. Thomson and Mossialos (2009) emphasised 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).

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 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 considered as 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 government scheme or insurance determine the household cost-sharing, which is a component of household out-of-pocket payment (OOP). The full cost of the services or goods concerned accounts for its two payer components: the third-party payer and the OOP. As the full costs of the services or goods concerned are also important information, the following memorandum items are included in the classification: government 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).

Relationship between financing schemes and financing agents

Financing agents are institutional units that manage one or more financing schemes: they collect revenues and/or purchase services under the rules of the given health care financing scheme(s). This includes households as financing agents for out-of-pocket payments.

SHA 2011 interprets financing schemes as the key components of the health financing system from the point of view of access to care, and hence connects them to providers and health care functions in the SHA's tri-axial system.

At the same time, from the point of view of the accountability of institutions in the health financing system, it is also important to consider the financing agents. Increasing accountability at the country level through improved governance and efficiency is a key policy issue. This requires an understanding of who manages the financial schemes

(financial resources) and how well they do this. In other words, at the country level financing agents may be a critical element of the analysis. Table 7.7 provides a tool to illustrate the institutional arrangements of a country's financing schemes.

As already mentioned, financing agents (FA) serve as key statistical units in producing national health accounts. While financing schemes are the key units for analysing how the consumption of health care goods and services is financed, the data concerning the relevant transactions are collected either from the financing agents (FA) that operate the different financing schemes or from the providers, depending on the national statistical system. To put it another way, the categories of health care financing schemes are key analytical units of SHA 2011 with respect to which data are to be collected from financing agents (FA) or providers. Annex D provides a classification of financing agents. Table 7.7 shows the possible financing agents for the main types of financing schemes.

Table 7.7. **Possible financing agents for the main categories of financing schemes**

Financing schemes	Financing agents	
	Revenue-collecting agencies	Purchasing agents
Government schemes	Government unit(s)	Government units: ministries, local governments NPISH Corporations
Social health insurance schemes	Government unit National Health Insurance Agency Social health insurance funds Private insurance corporations	National Health Insurance Agency Social health insurance funds Private insurance corporations
Compulsory private insurance schemes	Government units Private insurance corporations	Private insurance corporations Public corporations
Voluntary health insurance schemes	Private insurance corporations Social health insurance funds NPISH	Private insurance corporations Social health insurance funds NPISH
NPISH financing schemes	NPISH	NPISH
Enterprise financing schemes	Corporations	Corporations
Rest of the world financing schemes	RoW	RoW NPISH Government units

Source: IHAT for SHA 2011.

As already discussed, there are wide variations in the organisational settings of the basic health care financing schemes across countries. In the case of countries with complex institutional settings, it is of great importance to distinguish clearly between financing schemes and financing agents, and to clarify unambiguously the different possible roles of key institutional units involved in health financing (*e.g.* the government, the rest of the world).

In several countries there is a one-to-one correspondence between financing schemes and financing agents (Figure 7.3). For example, in Country A with a simple organisational arrangement, all government-financed care may be operated by local government units, voluntary insurance is offered by insurance companies, and households pay out-of-pocket for certain services.

The one-to-one correspondence is, however, not necessary from a theoretical point of view. Moreover, in reality, there are many countries where the relationship between financing schemes and financing agents is rather complex and has changed considerably over the past few years (Figure 7.4). For example:

- The same actor can serve as a financing agent for more than one financing scheme (*e.g.* private insurance corporations, besides offering voluntary insurance, may be involved in managing the social insurance scheme);
- Actors belonging to different institutional sectors of the economy can serve as financing agents for the same financing scheme (*e.g.* the compulsory social insurance scheme can be managed – at the same time in a given country – by both a social insurance agency and private insurance corporations);
- The same actor (*e.g.* the tax office) can act as a collecting organisation for more than one financing scheme (*e.g.* central government scheme and social insurance, etc.).

Figure 7.3. **The relationship between financing schemes and financing agents: one-to-one correspondence**

Country A. One-to-one correspondence between financing schemes and financing agents					
Financing schemes	Financing agents (Institutional units)				
	Government units (FA.1.1, FA.1.2)	Social insurance funds (FA.1.3)	Insurance corporations (FA.2)	Households (FA.5)	Rest of the world (FA.6)
Government schemes (HF.1.1)					
Compulsory social health insurance (HF.1.2.1)					
Voluntary health insurance (HF.2.1)					
Out-of-pocket payments (HF.3)					
Foreign aid programmes (HF.4)					

Source: IHAT for SHA 2011.

Expenditure by health care financing schemes and financing agents

While for international comparison the HCxHF and the HFxHP tables provide adequate information, for national purposes expenditure by both financing schemes and financing agents may be required. It may be possible to create sub-categories of financing schemes according to the financing agents that operate the given scheme, for example, "Central government financing schemes operated by NPISH"; "Social health insurance operated by social security funds"; or "Social health insurance operated by private insurance corporations". (A separate set of guidelines for the implementation of classifications of health care financing under SHA 2011 will provide concrete examples for this.)

This kind of table would present important information about the institutional arrangements of the particular financing schemes. The total spending by a financing scheme would be aggregated across all institutional units. When more than one type of institutional unit is involved in the operation of a given financing scheme, the table would show the role of each institutional unit.

The expenditure of a financing scheme includes the spending on health care goods and services and the administration of the given financing scheme. The administration of

Figure 7.4. **The relationship between financing schemes and financing agents: example of a more complex institutional setting**

Country B. Complex relationship between financing schemes and financing agents

Financing schemes	Financing agents (Institutional units)				
	Government units (FA.1.1, FA.1.2)	Social insurance funds (FA.1.3)	Insurance corporations (FA.2)	Households (FA.5)	Rest of the world (FA.6)
Government schemes (HF.1.1)					
Compulsory social health insurance (HF.1.2.1)					
Voluntary health insurance (HF.2.1)					
Out-of-pocket payments (HF.3)					
Foreign aid programmes (HF.4)					

Source: IHAT for SHA 2011.

a given financing scheme includes expenses related to revenue collection and purchasing. Therefore, if two different institutional units are involved in the revenue collection and purchasing, the administrative costs of both institutional units should be included.

This table may be used for cross-country comparison of the institutional characteristics of health financing and also for monitoring changes in the institutional arrangements of health financing schemes in countries with complex institutional arrangements, for example, changes in the institutional arrangement of compulsory insurance, or changes in the involvement of NGOs in managing government health programmes. Countries with simple institutional arrangements for health financing do not need such a table.

The relationship between financing schemes and financing agents from a data collection viewpoint

As already noted, in a statistical sense, HF is an analytical unit (similar to HC). The data collection units are the establishment units of financing agents or providers (depending on the country's statistical system) – similar to the data collection for HC, which is also collected from providers (or financing institutions).

In some countries (for example, the Netherlands), commercial health insurance companies operate both compulsory health insurance, which is heavily regulated by the government, and voluntary health insurance, which is regulated by EU regulations that allow only very limited government intervention. Units of the insurance company managing the compulsory insurance and units managing the voluntary health insurance should be considered as separate establishment units, in much the same way as inpatient and outpatient units within a hospital (despite the fact that there are units of the insurance company serving both activities).

For example, in Portugal, the main financing scheme is the National Health Service (HF.1.1 Government schemes). However, the data for preparing the table HCxHF are collected

from several sources: for example, from the ACSS, which is a body of the Ministry of Health operating the National Health Service and retail sale surveys for pharmaceuticals.

Distinguishing between government schemes and government as an institutional unit

Government is involved in the operation of the health financing system – in revenue-raising, pooling and purchasing – in several different ways. Figure 7.5 provides an example of the relationship between government schemes and the involvement of government as a provider of revenues and as a financing agent. The marked boxes in the second column indicate the government financing schemes (HF.1.1.1 and HF.1.1.2); the marked boxes in the first column indicate the revenues provided by the government; and the marked boxes in the third column indicate the government units acting as financing agents for HF.1.1.1 and HF.1.1.2.

Figure 7.5 shows that:

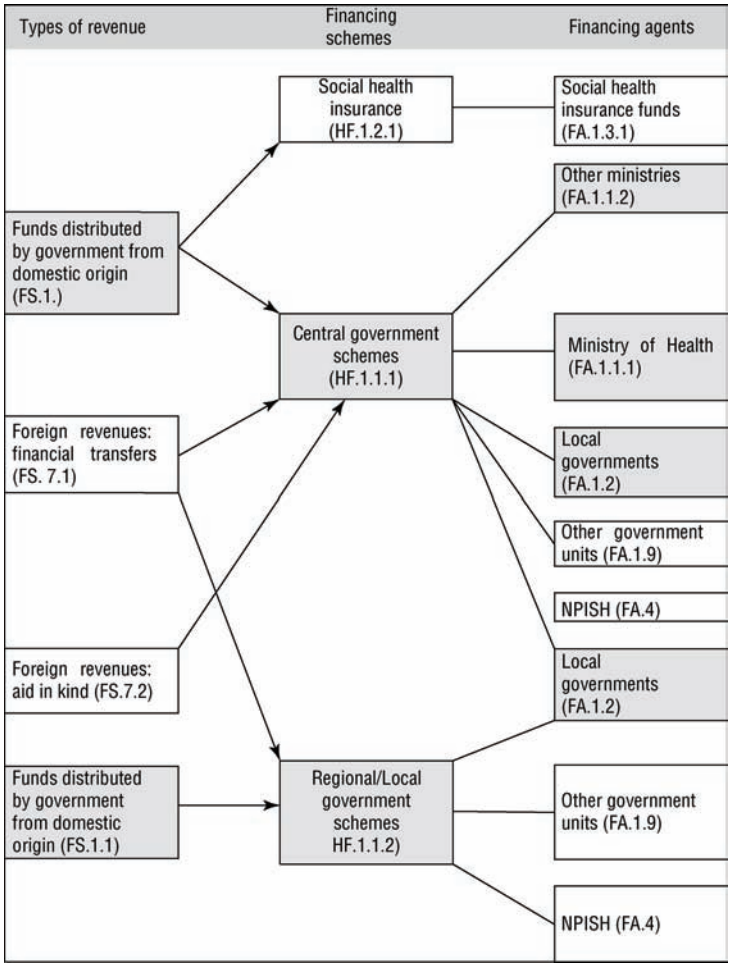
- The government provides revenues from domestic origin (FS.1) not only for the government schemes (HF.1.1), but also for other financing schemes (*e.g.* compulsory social insurance: HF.1.2.1, voluntary health insurance HF.2.1, etc.);
- The government schemes may receive revenues from sources other than the general revenues of the government (*e.g.* foreign aid: FS.7.2);
- The central government schemes (HF.1.1.1) may be managed by different government units (FA.1.1.2; FA.1.2; FA.1.9) and have NGOs as financing agents (FA.4);
- Local government schemes (HF.1.1.2), besides the general revenues of the local government, may receive grants from the central government (FS.1.1) and grants from foreign entities (FS.7.1);
- Local government financing schemes (HF.1.1.2) may be managed by local government units (FA.1.2), other government units (FA.1.9) and NGOs (FA.4).

Distinguishing between rest of the world financing schemes, foreign entities as providers of revenues and foreign entities as financing agents[23]

The role of foreign resources (from international agencies, foundations, etc.) in the financing of health care may be of great importance in lower-income countries. Here only the complex relationships between the health care financing schemes, their revenue and the institutional units are discussed. The shaded boxes in Figure 7.6 indicate the different types of rest-of-the-world involvement. Figure 7.6 illustrates:

- Foreign entities are involved mainly in providing financial resources and aid in kind for domestic health care financing schemes. The rest of the world (as a provider of revenues) may include international organisations, foreign governments and other foreign entities (including family living abroad – remittances). Figure 7.6 shows only the types of revenue (and does not indicate the institutional units from which the given revenue is collected).
- RoW may provide revenues for government schemes (HF.1.1) or NPISH health programmes (HF.2.2), or a foreign entity (*e.g.* a foundation) may set up a separate health programme that – if meeting certain criteria – could be regarded as a financing scheme (HF.4).
- A foreign (non-resident) institutional unit (FA.6) may be involved in managing RoW financing schemes (for example, a foreign NGO may implement a prevention programme that is financed from foreign aid).
- In some cases providers receive external funds directly. These cases refer to RoW as sources (revenues).

Figure 7.5. **An example of the relationship between government schemes, government as a provider of financial resources and government as a financing agent**



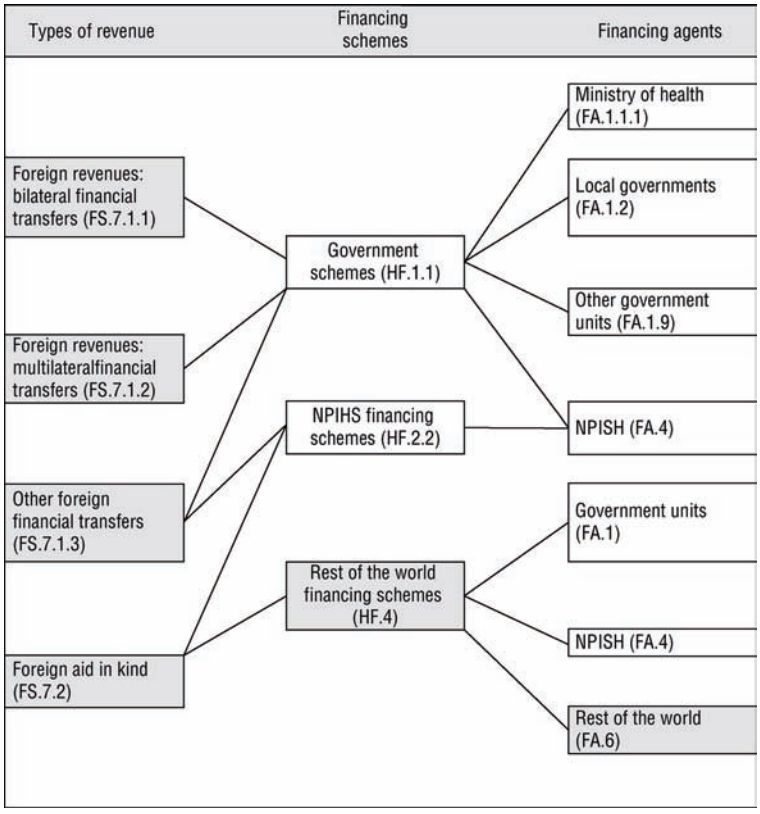
Source: IHAT for SHA 2011.

The treatment of surplus funds or deficits under SHA 2011[24]

The HCxHF and HPxHF tables show the spending by health care financing schemes in a given accounting period, while the HFxFS table refers to all revenues of health care financing schemes raised in the given period. A scheme's revenue may be greater or smaller than the expenditure on health care goods and services by the given scheme.[25] Therefore, the total expenditure in the HCxHF and HPxHF tables does not necessarily equal the total revenue in the HFxFS table. The differences between the sub-totals in HFxFS and HCxHF (revenue minus expense of each financing scheme) shows the surplus or deficit of the particular financing schemes in a given accounting period.

Social insurance schemes in several countries finance not only health care goods and services but other social services as well. In such cases, only "*health-relevant revenues*" and health-related expenditures should be taken into account. As revenues may not be fully separated between the different spending components of such social insurance schemes, a number of assumptions may be needed. It is possible to analyse the deficits and surpluses of such health insurance schemes, but this may be highly influenced by assumptions about how to calculate "health-related revenues".

Figure 7.6. **The possible roles of foreign resources and foreign (non-resident) institutional units in health financing**



Source: IHAT for SHA 2011.

An alternative tool for presenting the surplus or deficit is the table of sectoral accounts discussed in Annex D.

Relationship to other statistical systems

Figure 7.7 shows the concept of the financing scheme in the context of SHA 2011 and SNA 2008.

Main steps in adjusting SHA 1.0 or *NHA Producers Guide* of a country to SHA 2011 accounting of health financing

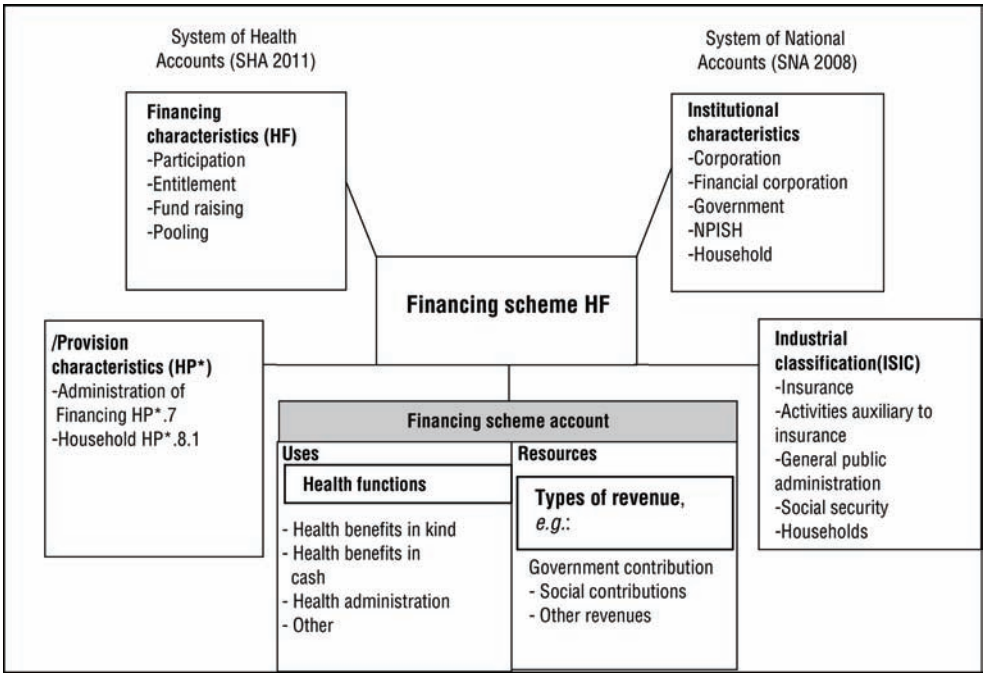
A *qualitative analysis* can be a good basis for the adjustment of a country's national health accounts to the SHA 2011 health financing framework. This may include:

- As a first step, clarifying the types of *health care financing schemes* (sub-systems) the country has (for example, based on Table 7.3 and the criteria tree in Figure 7.2);
- Defining the *types of revenues and financing agents for each financing scheme*. The clarification of all types of revenues and institutional units involved may require additional qualitative analysis in the case of government schemes and the rest of the world financing programmes (see Figures 7.5 and 7.6).

Based on this qualitative description:

- The correspondence between the SHA 1.0/PG categories of ICHA-HF used in the NHAs of the given country and the SHA 2011 categories of ICHA-HF can be made (see Table 7.4). In many cases this requires only changes in the naming;

Figure 7.7. **Financing schemes in the context of SHA 2011 and SNA 2008**



Source: IHAT for SHA 2011.

- The country-relevant categories of the proposed classification for financing agents and classification of revenues of health financing schemes can be identified;
- Any optional tools that may be relevant to the further development of the NHAs of the given country can be chosen (see proposed optional tables and sectoral accounts);
- It can be decided whether a specific analysis of foreign assistance is desirable.

Notes

1. For countries that have found it useful to identify who is purchasing the various production factors, the HFxFP table may also be relevant. An example of this is where some non-resident entities in the rest of the world (RoW) may supply in kind (or finance) specific inputs. A central government may concentrate on the payment of human resources.
2. FS.RI refers to the institutional units providing revenues to financing schemes. These are reporting items under the FS classification. See Chapter 8 for further detail.
3. Government financing programmes, compulsory social insurance, voluntary insurance, out-of-pocket payments, foreign aid programmes, etc.
4. Definitions of these concepts are provided in the next section of the Manual.
5. Financing schemes are a flexible approach to functional financing structures, *e.g.* they can include mixed functional arrangements such as public-private partnerships.
6. Traditionally in the Netherlands, private insurance companies could execute the social health insurance, just as the health insurance funds were allowed to execute private supplementary insurance. To do so separate legal structures were mandatory for each activity. Since the change in the financing structures in 2006, this is no longer the case, although separate accounts are required for each activity.
7. The HFxFS matrix 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 (including information on deficits/surpluses) concerning the major financing schemes separately. Sectoral accounts provide a tool for this.

8. The categories of the institutional sectors in SNA (such as households, corporations, government, rest of the world) are used to represent institutional units as providers of revenues in the relevant SHA tables.

9. Gottret and Schieber (2006) proposed the following financing arrangements, which involve different risk-pooling mechanisms: Ministry of Health/National health service systems, Social health insurance systems, Community-based health insurance and Private or voluntary health insurance.

10. Generally speaking, public law governs the relationship between individuals (citizens, companies) and the state. Private law is the area of law that affects the relationships between individuals or groups without the intervention of the state or government. This distinction is often conflated.

11. The word *scheme* is widely used in different areas, including mathematics, linguistics and management, with different meanings, including: an elaborate and systematic plan of action; a system: a group of independent but interrelated elements comprising a unified whole; or a systematic or organised configuration. The term *health care financing scheme* is widely used in the health policy literature as a synonym for a health financing arrangement or a health financing sub-system.

12. Table 7.4 compares the structure of the ICHA-HF classification in SHA 2011 with that in SHA 1.0.

13. This category includes informal payments. *De facto* the cost-sharing would include informal payments. However, usually informal or under-the-table payments are not seen as cost-sharing but as genuine out-of-pocket payments.

14. Conditional cash transfers by the government (CCT) are payments that are conditioned on specific action by the recipients, *i.e.* requiring individuals receiving cash payments to undertake a specific action, for example, attendance at primary care centres for preventive interventions (childhood immunisation and pregnancy care, such as perinatal visits and nutrition). Over the past few years, several Latin American and African countries have introduced CCT programmes to encourage health care utilisation and health-seeking behaviour. For more detail, see WHO (2008c).

15. Insured people enrol with a fund.

16. Tax credits are amounts deductible from the tax that otherwise would be payable.

17. The savings account may cover, besides the owner of the account, dependent family members, and hence, there is pooling only within this very small group. Because the savings account can be maintained over many years, it provides for inter-temporal pooling.

18. Voluntary health care payment schemes (HF.2) do not have to come from a private initiative. For example, the Thai government initiated a voluntary health insurance scheme, and the current Chinese NRCMS is also a voluntary insurance scheme that was initiated by the government.

19. While out-of-pocket expenditures are the leading cause of potentially catastrophic and impoverishing levels of health payments globally, the text here should not be read to imply that other forms of contributions do not impose a financial burden on households.

20. According to SNA, primary income is the income that resident units receive by virtue of their participation in the production process, along with income receivable by owners of financial or other assets in return for placing those assets at the disposal of other institutional units.

21. The use of the word "voluntary" here is debatable, as the government or insurance scheme may impose the obligation to co-pay for the services.

22. The current practice in using the terms "public" and "private" in health financing has some ambiguity. This 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.)

23. The arrows show the flows of revenues and the solid lines show the relationships between financing schemes and financing agents.

24. The arrows show the flows of revenues and the solid lines show the relationships between financing schemes and financing agents.

25. Under SHA 1.0/NHA tables, total current health expenditure is required to be equal in the HCxHF and HFxFS tables. The HFxFS table is expected to show the sources of the expenditure used for final consumption in the given accounting period. SHA 2011 has a different interpretation of the HFxFS table.