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National Health Accounts: NHA Global Policy Brief

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Meeting Millennium Development Goals:
Using National Health Accounts to Understand Reproductive Health Financing

Without knowing the current level of the resource envelope for RH services and its distribution among providers, services, and beneficiaries, it is difficult to develop sustainable and informed strategies for expanding access to these services, potentially jeopardizing the achievement of MDG maternal mortality targets.

Inclusion of a maternal mortality reduction target (by 75 percent by 2015) in the Millennium Development Goals (MDG)[1] has resulted in countries setting ambitious agendas for enhancing reproductive health (RH) services, such as expanding availability of these services, improving their quality, and adapting them to more appropriately meet user needs. Such ambitious agendas may require additional resource commitments or reallocation of existing funds.

However, policymakers in most middle- and low-income countries lack critical information about current national spending on RH care: how much is spent, the sources of financing, the patterns of resource flows, and how the expenditures link to RH outcomes. This lack of information limits their ability to develop appropriate, sustainable policies that will lead their countries to achieve MDG maternal mortality targets.

One internationally recognized tool that can help inform policymakers about the financial flows for reproductive health is National Health Accounts (NHA). This concept paper describes the possible adaptation of this tool to the RH context.

What are Health Accounts?

General National Health Accounts

In response to the growing need for health expenditure information for evidence-based policymaking, international researchers with support from various international organizations such as the United States Agency for International Development (USAID), World Health Organization (WHO), World Bank, and Swedish International Development Cooperation Agency (Sida) have promoted the development and implementation of National Health Accounts in middle- and low-income countries. To date, approximately 70 developing countries have implemented the tool and many aim to do so on a regular basis, as part of routine data collection systems. Because NHA serves as an international standard for tracking resource flows, its data are comparable across countries.

NHA, sometimes referred to as a *general* NHA, is a framework for capturing *total* health expenditures in a given country for a given year.[2] Using a standard

[1] MDGs commit the international community to an expanded vision of development, one that vigorously promotes human development as key to sustaining social and economic progress in all countries. www.developmentgoals.org

[2] A complete description of the NHA framework is provided in: World Health Organization, World Bank, and United States Agency for International Development. 2003. *Guide to producing National Health Accounts with special applications for low-income and middle-income countries.* Geneva. For an overview of the NHA methodology, see Partners for Health Reform*plus*. May 2003. *Understanding National Health Accounts: The Methodology and Implementation Process*. Primer for Policymakers. Bethesda, MD: PHR*plus*, Abt Associates Inc.

two-dimensional table format, NHA tracks the annual flow of funds through the health system:

- from their financing sources, such as the ministry of finance (MOF), donors, and households,
- through their financing agents, which are the principal managers of health funds and include entities such as the ministry of health (MOH) and nongovernmental organizations (NGOs),
- to providers, such as hospitals, clinics, dispensaries, pharmacies, and traditional healers, and
- to functions, or end uses – the types of service or products produced including curative, preventive, and rehabilitative care, and administration.

Figures 1 and 2 illustrate a general NHA table and flow of funds through the health sector.

Furthermore, the NHA framework allows for additional stratification of funding flows by disease-specific areas (malaria, HIV/AIDS, and so forth) and intervention clusters (reproductive health, child health care, etc.). These stratifications involve additional expenditure reviews within the NHA framework and are referred to as NHA *subanalyses*. Due in part to their specific policy themes, such subanalyses, particularly when done on a routine basis, move one step closer to linking spending patterns to actual results.

Reproductive Health Subanalysis

Like the general NHA, the NHA subanalysis for reproductive health captures and organizes information on health expenditures in the standard table format, from financing sources to end uses, but does so only for reproductive health. Often, the subanalysis is done concurrently with a general NHA estimation, and this allows for the placement of RH expenditure information within the context of what is being spent for overall health care. In accordance with NHA principles, the RH subanalysis is intended primarily for use in policymaking and as such should be designed to address key policy questions.

The cost of a subanalysis depends on the extent to which primary data must be collected (see "Data Collection" below), the subanalysis process is to be institutionalized within the regular government data retrieval processes, and capacity building is

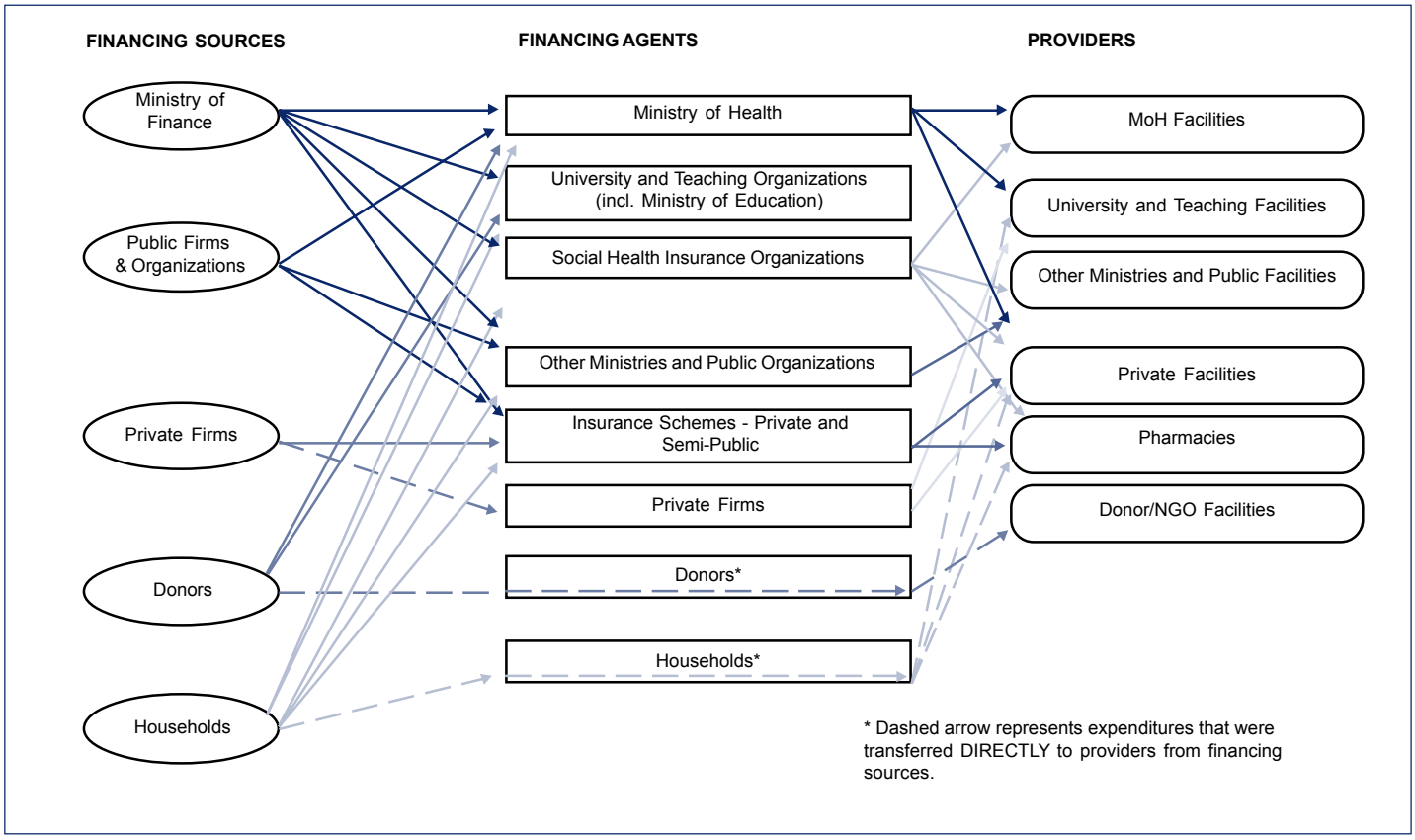
Figure 1: NHA Tables

	Financing Agents				
Providers	HF.1.1.1.1 **MoH**	HF.1.1.1.2 **MoE**	HF.2.2 **Other private insurance**	HF.2.3 **Private house-holds out-of-pocket payment**	
HP.1.1.1 **Public general hospitals**	W		X		**W+X**
HP.1.1.2 **Private general hospitals**		C		F	**C+F**
HP.3.4.5.1 **Public outpatient clinics**			Y		**Y**
TOTALS	**W**	**C**	**X+Y**	**F**	**G**

** direct transfer of payment*

	Providers			
Function	HP.1.1.1 **Public general hospitals**	HP.1.1.2 **Private general hospitals**	HP.3.4.5.1 **Public outpatient clinics**	**TOTALS**
HC.1.1 **Inpatient curative care**	L	P	S	L+P+S
HC.1.3 **Outpatient curative care**	M	Q	T	M+Q+T
HC.6.3 **Prevention of communicable diseases**	N			N
HC.7 **Health administration and health insurance**	O	R	U	O+R+U
TOTALS	**L+M+N+O=W+X**	**P+Q+R=C+F**	**S+T+U=Y**	**G**

Figure 2: NHA Shows the *Flow* of Funds



required to implement the subanalysis. The time needed to implement a subanalysis depends on the schedule of the government leading the NHA process and the timeline of the general NHA estimation, which can take up to nine months to complete.

To date, the subanalysis has been implemented in Egypt, Jordan, and Rwanda, supported by the USAID Partners for Health Reform*plus* (PHR*plus*) project. Efforts are underway for a similar estimation in Karnataka, India, supported by the UNFPA Resource Flows project, and in Mexico, supported by the Mexican Institute of Public Health. Similar studies were carried out in the Philippines and Egypt in the 1990s. A review of costing and financing of RH services which used the national accounting framework was also conducted. It covers Bangladesh, Rajastan (India), and Sri Lanka.[3] Given the growing recognition of the value of such subanalysis estimations, a multi-donor and multi-partner global working group is currently being assembled to promote such studies and to develop a coordinated methodological approach for implementing the RH subanalysis within the NHA framework.

[3] Institute of Policy Studies, Health Policy Programme. July 2004. *Review of Costs and Financing of Reproductive Health Services.* Prepared for the World Bank's South Asia Health Nutrition and Population Unit. Colombo, Sri Lanka: IDS.

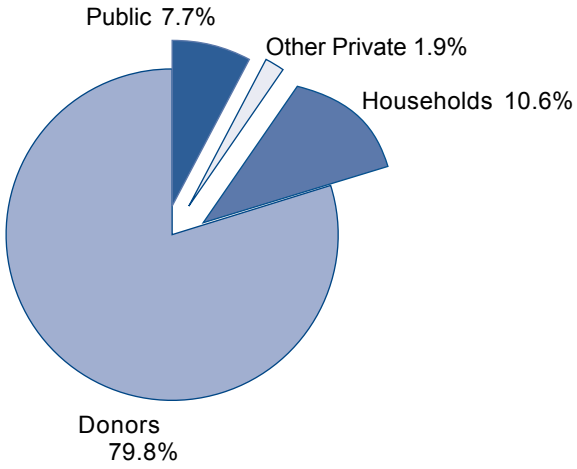
How the RH Subanalysis Contributes to Sound Policies

Prior to launching a subanalysis effort, the local NHA team needs to outline the key policy questions that should be addressed by the RH subanalysis. Experience shows that the subanalysis can address the following key issues:

- **How much is spent on reproductive health?** Despite efforts to reduce maternal mortality and morbidity, unwanted pregnancies, and spread of sexually transmitted infections (STIs), middle- and low-income countries continue to face serious challenges. Understanding the resource envelope for these RH services would be a good starting point from which to work toward MDG targets.
- **What is the reliance on donors for RH services?** Although developing country governments have expressed great willingness to address RH issues, donors still provide a substantial share of RH resources, particularly for the supply of contraceptives and other RH commodities, and particularly in sub-Saharan Africa. Hence, there is need to understand the implications that withdrawal of donor funding would have on provision of RH services. Figure 3 illustrates the breakdown of financing sources of reproductive health care in Rwanda.

- **What proportion of RH financing comes from private sources such as households?** Current country information tracking systems, particularly in low- and middle-income countries, offer at least partial data on donor and government contributions to reproductive health. However, households' out-of-pocket spending may also be a major contributor, particularly for inpatient and outpatient curative care services. Policymakers may be interested in understanding the burden that this spending places on households and how it may affect the use or non-use of RH services. (See Figure 3.)

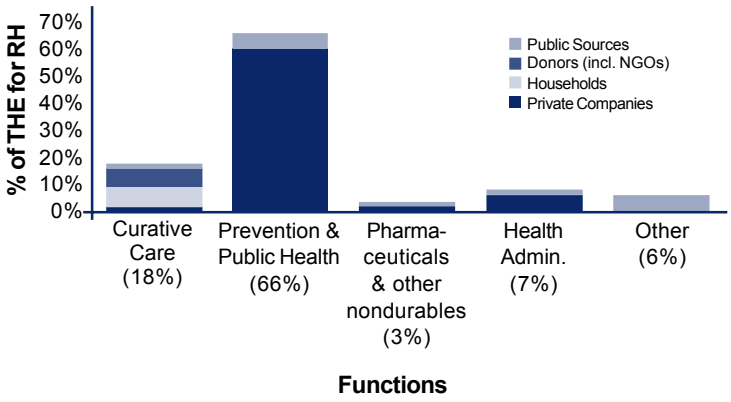
Figure 3. Who Funds RH in Rwanda?



Source: Republic of Rwanda, Ministry of Health. 2005. *Rwanda National Health Accounts 2002*. Kigali

- **What is the relationship between expenditure and outcomes?** Despite extensive commitments to reproductive health, it is not yet clear how much is actually spent and what the outcomes are. That is, what do we get for the money spent? Looking at expenditure per "couple-year of protection" (CYP) for each contraceptive method could be one way forward.
- **What types of services are financed by RH funds?** Information on the amounts spent on RH functions – family planning, maternal health, and other RH services – can elucidate the extent to which government policies are actually being implemented and inform the process for setting resource allocation priorities among RH services. Figure 4 shows the types of RH services financed in Rwanda and the percentage of funds provided to each service by financing source.

Figure 4. Types of RH Services by Financing Source, Rwanda 2002



Source: Republic of Rwanda, Ministry of Health. 2005. *Rwanda National Health Accounts 2002*. Kigali

Scope of the RH Subanalysis

What expenditure information is included in a RH subanalysis? This depends upon the policy questions identified for the exercise, the country context for RH service delivery, and what can be feasibly measured.

The NHA subanalysis bases its scope on the WHO definition of reproductive health (see box).

WHO definition of Reproductive Health

Reproductive health is a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections. (http://www.rho.org/html/definition_.htm)

This definition is broad, and, on the operational level, countries may implement different types of RH programs. Activities could include:

- Family planning services – all programs, goods, and services intended to assist women control their fertility, and all counseling and health education and information

- △ Outpatient counseling and issuance of contraceptive commodities, e.g., IUD insertions, injectables
- △ Retail sale of family planning commodities such as oral contraceptives, condoms, and spermicidals
- △ Female and male surgical sterilization
- △ Programs that support or promote family planning such as IEC (information, education, communication), public awareness, health education campaigns, training, and research

▲ Maternal health services

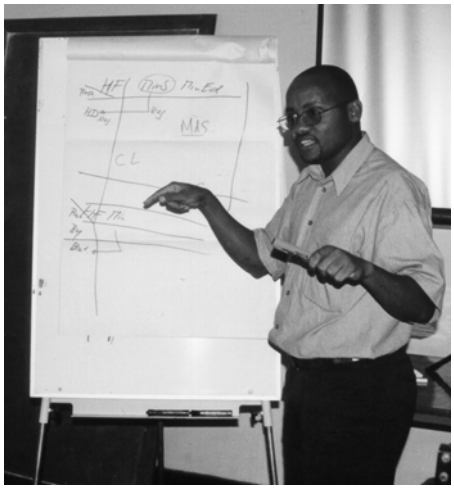
- △ Prenatal and postnatal care
- △ Deliveries
- △ Emergency obstetric care
- △ Programs that support maternal care

▲ Fertility counseling, fertility drugs or procedures, etc.

▲ General gynecological care (routine examinations; Pap smears; health education; treatment of vaginal, pelvic, and urinary tract infections; mammograms; uterine, cervical, ovarian, breast cancers; etc.)

▲ STIs if applicable

As stated earlier, while defining boundaries in a way that allows country comparability of RH findings is an important secondary goal of the subanalysis, it is also critical that the boundaries used, i.e., types of expenditures tracked, be useful to informing national RH policy issues. For example, what may be considered a RH service in one country may not be such in another country. Treatment of STIs may be the responsibility of the RH program or HIV/AIDS program, depending on the historical context and programmatic response of the country to these issues. Countries with low HIV/AIDS prevalence rates tend to deliver STI services within the overall RH program; India and other countries that historically have been concerned with population issues associate STI services with RH care. In contrast, high HIV/AIDS prevalence countries, such as Rwanda, offer RH services through their HIV/AIDS programs.



Indicators Tracked by the RH Subanalysis

Based on the agreed-upon policy issues and scope of the subanalysis, a country NHA team should be able to track at a minimum the financial indicators in the following table.

NHA RH Indicators

General indicators	▲ Total RH expenditures ▲ RH expenditures per woman of reproductive age ▲ RH expenditures as % of GDP ▲ RH expenditures as % of Total Health Expenditures (THE)
Financing sources indicators	▲ Public contribution as % of THE for RH ▲ Private contribution (by households and other private entities) as % of THE for RH ▲ Donor contribution % of THE for RH
Household expenditure indicators	▲ Total household spending as % of THE for RH ▲ Out-of-pocket spending as % of THE for RH ▲ Out-of-pocket spending per woman of reproductive age
Financing agent indicators	▲ % of RH funds managed by △ the Ministry of Health and other public entities △ NGOs and donors △ Directly by households (through out-of-pocket expenditures)
Provider indicators	▲ Provider spending as % of THE for RH △ By ownership (public and private) △ By facility (hospital, health center, shops, etc.)
Indicators by NHA functions	▲ Curative care as % of THE for RH ▲ Prevention and public health programs as % of THE for RH ▲ Health administration as % of THE for RH ▲ Linking of financing sources to their end uses: △ E.g., % of curative care financed by donors versus households versus the government
RH functional categories	▲ Maternal health services (including prenatal, postnatal, and delivery proportions) as % of THE for RH ▲ Family planning as % of THE for RH ▲ Prevention and public health programs as a % of THE for RH ▲ Administration as a % of THE for RH ▲ Expenditure per delivery in a facility ▲ Expenditure breakdown by contraceptive method mix △ E.g., % of oral contraceptive expenditures financed by households versus the government △ E.g., expenditure versus utilization of various contraceptive types

Implementation of the RH Subanalysis

Our approach is to, whenever possible, do the RH subanalysis within the framework of the general NHA process, i.e., as an extension of the general NHA. The process should be country-owned and government-led, making its findings more likely to be used in policymaking.

Implementers of the Subanalysis

Inclusion of a RH subanalysis in the general NHA makes it imperative that RH stakeholders and program officials be involved in the NHA process. Stakeholders may vary by country, but from among them, a country ideally forms two bodies to carry out the NHA and subanalysis: overall guidance comes from a national NHA *steering committee* (SC) of policymakers from the public, private, and donor sectors of the health system. Direct implementation is the responsibility of a *technical team*, a multi-sectoral group of technocrats coordinated by a government ministry, usually the MOH (and in many instances the MOH department of planning). RH stakeholders should participate in both the SC and the technical team. A more specific division of duties between the SC and the technical team can be summarized as follows:

- Steering committee
  - Guides the NHA subanalysis to ensure that it is policy-relevant (identifies the policy questions to be addressed by the study)
  - Oversees implementation of the subanalysis and facilitates data retrieval
  - Approves the NHA report and sanctions its use to inform health policy, planning, monitoring and evaluation, and so forth
- Technical team
  - Holds sensitization and progress meetings with the SC
  - Maps out the profile of RH care and identifies data sources for needed information (aimed to address SC policy concerns)
  - Designs and implements the workplan – the plan for collecting both primary and secondary data, entry and analysis of the data, and report writing

Data Collection

Data can be obtained from both secondary and primary sources. The types of data collected depend upon the primary objectives of the subanalysis (which are based upon the key policy questions identified by the SC), the existence of needed data, and the feasibility of retrieving those data.

Generally speaking, expenditure data are needed from all elements of the health system, namely:

- Providers of RH services including hospitals, clinics, physician offices, pharmacies, and traditional birth attendants
- Donors
- NGOs
- Relevant government entities such as ministries of finance, health, and women
- Insurance companies
- Employers
- Households

The first step in organizing the data collection process is to review and list all available data, or secondary data sources. Examples of secondary data include MOF executed budgets, completed Demographic and Health Surveys and provider-based surveys, existing health information system data (typically collected by the MOH) on RH services and utilization, and data retrieved from the USAID NEWVERN information system, which tracks contraceptive commodities provided by international donors. Once secondary data are collected, the team identifies gaps that need to be filled through primary data collection, namely, the implementation of surveys. Because primary data collection is usually the most costly element of the NHA exercise, budgetary requirements for a RH subanalysis depend greatly on how much primary data collection is needed.

Completing the Subanalysis

Once policy goals are determined and data are collected, the data are organized into the NHA tables. These tables illustrate the flow of funds from financing sources, to financing agents, to providers and functions. RH findings must be interpreted in terms of policy goals, and then reported in a way that is both understandable and useful to RH decision makers and other stakeholders. Information on RH financial flows expands the evidence base on which strategic planning and policy decisions are made and in this way can support the achievement of RH priorities and MDG targets.

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