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NATIONAL HEALTH ACCOUNTS

REPRODUCTIVE HEALTH SUBACCOUNTS PARTICIPANT'S MANUAL

USAID FROM THE AMERICAN PEOPLE | Africa's Health in 2010

HEALTH SYSTEMS 20/20

March 2008
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National Health Accounts

Reproductive Health Subaccounts

Training Manual

DISCLAIMER
The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

Foreword

Dear future RH subaccounts trainers and trainees,

The National Health Accounts (NHA) methodology is an internationally recognized and accepted tool for tracking flows of funding through health systems – from their financing sources, to their principal managers, end users and end uses. Generally conducted in tandem with the NHA, the subaccounts are an additional, more detailed report of spending levels and patterns for a particular component of health care; specific to this guide, Reproductive Health (RH). The RH subaccount is a comprehensive and consistent way to evaluate RH expenditure data to help guide the allocation of limited resources among various needs. Since the RH subaccount uses the internationally recognized NHA framework, its expenditure findings can be compared across countries. Data can be used to track trends in expenditure levels, to monitor patterns of resource use over time, and to evaluate how the resource use relates to achieve RH program goals.

Policy decisions about the delivery of RH services and goals must be based on concrete information to produce the best outcome. Policy makers are apt to pay particular attention to this data since the need to understand the global burden of RH associated illnesses has intensified because of a growing interest in the progress of the Millennium Development Goals.

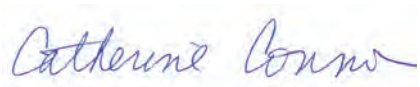
The following pages comprise the National Health Accounts Reproductive Health Subaccounts Participants Manual. The goal of this manual, as its name suggests, is to familiarize trainers and trainees on the methodology of the RH subaccount as well as to reinforce the importance and usefulness of tracking resources associated with RH. The manual is a complete toolkit with lectures, PowerPoint presentations, interactive exercises and supplemental readings that has been designed, and produced using the Reproductive Health Subaccounts Guidelines. These Guidelines were written by an international working group including support from WHO's departments of Health System Financing (WHO/HSF) and Making Pregnancy Safer (WHO/MPS), and Reproductive Health and Research (WHO/RHR); the United States Agency for International Development/Partners for Health Reform*plus* (PHR*plus*) Project and its successor the Health Systems 20/20 (HS 20/20) project; the United Nations Population Fund (UNFPA), the Netherlands Interdisciplinary Demographic Institute (NIDI), the Inter-

American Development Bank (IDB), and the Partnership for Maternal, Newborn and Child Health (PMNCH). The methodology aims to be internationally applicable in accordance with the NHA approach and incorporates lessons learned from Rwanda, Malawi, Ethiopia and Morocco.

The Health Systems 20/20 and Africa's Health in 2010 staff and their partners have served as global leaders in assisting countries world-wide to conduct and implement the NHA and subaccounts methodologies. Using years of technical experience, this manual has been designed to enable NHA teams to teach the RH subaccount methodology in a sustainable way in hopes of institutionalizing its implementation and replication in more countries.

Sincerely,

Doyin Oluwole
Project Director
Africa's Health in 2010



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This training manual was written and compiled by Manjiri Bhawalkar with input from Susna De with funding from the Africa's Health in 2010 and Health Systems 20/20 projects. The training manual was principally developed using the Reproductive Health Subaccounts Guidelines which were written by an international working group including support from WHO's departments of Health System Financing (WHO/HSF) and Making Pregnancy Safer (WHO/MPS), and Reproductive Health and Research (WHO/RHR); the United States Agency for International Development/Partners for Health Reformplus (PHRplus) Project and its successor the Health Systems 20/20 (HS 20/20) project; the United Nations Population Fund (UNFPA), the Netherlands Interdisciplinary Demographic Institute (NIDI), the Inter-American Development Bank (IDB), and the Partnership for Maternal, Newborn and Child Health (PMNCH).

The training manual has been repeatedly field tested in country and regional NHA trainings throughout the world and the authors would especially like to thank the training participants, who are too numerous to name individually, but provided valuable input to the content of the manual and helped to shape its current form.

The authors greatly appreciate the contributions of Dale Huntington of WHO/RHR, Patricia Hernandez of WHO/HSF, and Steve Musau from the Africa's Health in 2010 project for their technical review of the manual and their insightful additions to its content. The authors would also like to recognize Takondwa Mwase, who has provided years of his NHA expertise to the completeness and technical quality of this manual as well as previous versions.

Finally, the authors are tremendously grateful to Linda Moll at Health Systems 20/20 for editing the training manual, to Maria Claudia De Valdenebro for her contributions to the formatting of the toolkit, as well as to Health Systems 20/20 staff, Jenna Wright and Ellie Brown who provided extensive and thoughtful input to the finalization of the training manual.

The authors of the manual, as well as its many contributors, sincerely hope that it will prove useful to not only Africa's Health in 2010, Health Systems 20/20 and subsequent USAID projects, but also to donor partners and especially to NHA country practioners.

Contents

Introduction to Reproductive Health Subaccounts 1
The Need for Reproductive Health Subaccounts Training Materials 1
Using the Manual 2
Target audiences 2
Objective of the training 3
Training approach 3
Organization of the manual 4
Teaching each unit 4
Materials needed for the training 5
Participant Manual: 5
Timeframe for the workshop 6
Participant Information Sheet 7
Sample Agendas 9
Sample Agenda General NHA with RH Subaccounts Training 9
Sample Agenda RH Subaccounts Training 14
Pre-test for Subaccounts Training 17
Post-test for Subaccounts Training 24
Answer Key - Pre and Post-test for Reproductive Health Subaccounts Training 31

Unit 1. Introduction toReproductive Health Subaccounts 41
Unit 1 - Slide Presentation 43
Unit 1 - Exercises 59
Unit 1 - Answers 61
Unit 1 - Handout - Proposed Indicators for the Reproductive Health Subaccount 63

Unit 2. Definitions and Boundaries for the Reproductive Health Subaccounts 65
Unit 2 - Slide Presentation 67
Unit 2 - Exercises 79
Unit 2 - Answers 83
Unit 2 - Handout 1 Relevant ICD – 10 categories for RH subaccount 87
Unit 2 - Handout 2 90

Unit 3. Concept of Classifications for Reproductive Health Subaccounts..... 91
Unit 3 - Slide Presentations 93
Unit 3 - Exercises..... 115
Unit 3 - Answers..... 117
Unit 3 - Handouts 119
ICHA RH Function Classification 119
ICHA RH Provider Classification 122
ICHA RH Financing Agent Classifications 123
ICHA RH Financing Source Classifications 123

Unit 4. Setting-up and Reading the Matrices..... 125
Unit 4 - Slide Presentation 127
Unit 4 - Exercises..... 137
Unit 4 - Answers..... 139
Unit 4 - Handout 141
Example of Financing Sources X Financing Agents (FS X HF) Reproductive Health Subaccounts Table 141
Example of Financing Agents X Providers (HF X HP) Reproductive Health Subaccounts Table..... 142
Example of Financing Agents X Health Care Function (HF x HC) Reproductive Health Subaccounts Table 143
Example of Providers X Health Care Function (HP x HC) Reproductive Health Subaccounts Table..... 144

Unit 5. Data Collection Approach 145
Unit 5 - Slide Presentation 147
Unit 5 - Application Exercises 163
Unit 5 - Answers..... 167
Unit 5 - Handout 171

Unit 6. Data Analysis Approach.....173
Unit 6 - Slide Presentation 175
Unit 6 - Exercises..... 207
Unit 6 - Answers..... 219
Unit 6 - Handout 233
RH Case Study Codes 233

Unit 7. Implementation Process for Reproductive Health Subaccounts 235
Unit 7 - Slide Presentations 237
Unit 7 - Exercises..... 249
Unit 7 - Answers..... 251

Acronyms

ACT	Artemisinin-based combination therapy
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
CAMERWA	Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda
CH	Child Health
CMS	Centers for Medicare and Medicaid Services
DFID	Department for International Development
DHS	Demographic and Health Surveys
FHI	Family Health International
FP	Family Planning
FS	Financing Source
GTZ	German Agency for Technical Cooperation
HC	Health Care Function
HCR	Health Related Expenditures
HF	Financing Agent
HH	Household
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HP	Health Provider
HS 20/20	Health Systems 20/20
ICHA	International Classification for Health Accounts
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IP	Inpatient Care
MCH	Maternal and Child Health
MDG	Millenium Development Goal
MoF	Ministry of Finance
MoH	Ministry of Health
NHA	National Health Accounts
NHE	National Health Expediture
NGO	Non-Governmental Organization

NIDI	Netherlands Interdisciplinary Demographic Institute
NPISH	Non-profit Organizations Serving Households
OB-GYN	Obstetrics/Gynecology
OECD	Organization for Economic Cooperation and Development
OOP	Out-of-Pocket
OP	Outpatient Care
PG	Producer's Guide
PHR*plus*	Partners for Health Reform*plus*
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RC	Resource Cost
RH	Reproductive Health
R&D	Research and Development
SC	Steering Committee
SHA	System of Health Accounts
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
THE	Total Health Expenditure
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

I Introduction to Reproductive Health Subaccounts

The Need for Reproductive Health Subaccounts Training Materials

During a special session of the United Nations General Assembly that took place five years after the International Conference on Population and Development in Cairo (ICPD+5) health systems stakeholders set a target of universal access to quality RH services by 2015. And while improving RH is not a specific Millennium Development Goal, there has been significant acknowledgement that the attainment of RH is fundamental for meeting other MDG goals such as fighting poverty.

Improvements in RH services require significant resource commitments as well as efficient and effective use of those resources. But in order to properly address these issues, country leaders will first need to understand how much is currently being spent on RH and what that money is being spent on. Policymakers will require, on a regular basis, comprehensive data on the flows of RH funds in order to adjust policy to reflect the needs of the country and the current distribution of funding.

The National Health Accounts (NHA) methodology is an internationally recognized and accepted tool for tracking flows of funding through country health systems – from their financing sources, to their principal managers, end users and end uses. Generally conducted in tandem with the NHA, the RH subaccounts are an additional, more detailed report of spending levels and patterns specific to RH. The RH subaccount is a comprehensive and consistent way to evaluate RH expenditure data to help guide the allocation of limited resources among various needs.

To date, approximately 45 middle- and low-income countries worldwide have implemented the NHA methodology, some including the RH subaccount, and numerous others are about to follow suit.

To facilitate this process, the United States Agency for International Development (USAID) funded Africa 2010 and Health Systems 20/20 projects to develop this manual to assist RH subaccounts trainers from low- and middle-income countries in their efforts to design and conduct trainings to teach the methodology.

The manual aims to fulfill the worldwide need for guidance on teaching the RH subaccounts methodology, particularly for the unique health sector environments and challenges exhibited in middle- and low-income countries where financial information systems may not be well developed, data from the private sector may not be forthcoming, and the general size of the health system may not have been previously estimated. The training manual is intended to follow the *Guide to Producing Reproductive Health Subaccounts* within the NHA framework, which explains the latest technical developments in the RH methodology. The manual has been pre-tested at regional and in-country training sessions and feedback from workshop participants and trainers has been incorporated into its content.

Note to Trainers: Please download PowerPoint slides that go with this manual, as the notes section in each slide contains useful tips and relevant information. The PowerPoint slides can be downloaded from www.healthsystems2020.org and http://africahealth2010.aed.org/

Using the Manual

Target audiences

This manual has been primarily designed as a tool for trainers to use for teaching comprehensive technical information using an interactive approach. As such, the manual contains training material for both trainers and trainees.

Trainers

A RH subaccounts trainer ideally has had formal training on the NHA and RH subaccounts methodologies and practical experience producing both analyses at least once.

Trainees

Participants should be individuals with a health finance and/or reproductive health background who will need the theoretical and practical information provided by this manual. The manual can also be adapted to deliver an overview of NHA to policymakers, MOH staff, and other audiences who would benefit from understanding NHA and RH subaccounts even though they would not perform the analysis.

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Objective of the training

By the end of the training workshop, the trainer will have prepared participants who are potential NHA team members and/or researchers to complete an RH subaccounts analysis as part of the general NHA or as its own estimation. Senior decision makers will possess sufficient knowledge about RH subaccounts to use the findings presented by NHA teams in health policymaking.

Training approach

The manual presents guidelines on how to introduce the concepts and methodology of the RH subaccounts in an easily understandable manner. At the same time, the manual allows the trainer great flexibility to modify the materials to accommodate its level of technicality to the target audience and to incorporate country- or region-specific issues into the content of an individual training program. The manual follows an interactive approach that simulates real-life scenarios and methodological challenges that enable a clear understanding of RH subaccounts.

The manual contains content to help the trainer with both technical information and teaching methodology. The manual uses a combination of reading and lectures to introduce technical material, and group discussions based on exercises, discussion questions, and case studies to engage students in interactive, "hands-on" learning. The classroom discussions and exercises, developed from real-life NHA experiences, in particular reinforce students' understanding of NHA by asking them to apply their new knowledge and anticipate challenges they will face in conducting NHA. The trainer must download the PowerPoint slides separately, as the notes section includes useful tips and relevant information.

Content

The technical content of the training is divided into seven units:

- Introduction to RH Subaccounts
- Definitions and Boundaries for the RH Subaccounts
- Concept of Classifications for the RH Subaccounts
- Setting up and Reading the RH tables
- Data Collection Approach
- Data Analysis Approach
- Implementation Process for RH Subaccounts

In addition to presenting and practicing the methodology, the content of the manual covers suggested approaches to NHA and RH subaccounts planning in-country, the policy relevance of RH subaccounts, and the issues surrounding the institutionalization of the methodology. The trainer can also use the workshop as a venue to generate country team consensus or help participants with steps related to planning their own RH subaccount, such as the development of a workplan, a NHA team and steering committee organogram, defining a set of boundaries, classifications, and framework, and, finally, developing a data plan.

The units are ordered to follow the chronology of the NHA process. As will be seen in the sample workshop agendas given later in this orientation section, the units need not be taught in that order but rather according to the needs and skills of the workshop participants.

Organization of the manual

It is recommended that the trainer first review the technical material and guidelines for each topical unit. The guidelines suggest how each topic should be introduced to participants. The units also contain discussion and exercise questions intended to help participants to better grasp the technical concepts. The trainer can customize the curriculum to the audience.

The accompanying PowerPoint presentations for each unit are intended to help the trainers during the delivery of their presentations. The trainers can modify the presentation as they see necessary.

This trainer's manual has been designed to include both the guidelines for the trainers to teach the Reproductive Health Subaccounts as well as exercises for participants to reinforce the concepts introduced in the presentations and provide participants a flavor of the real-life methodological scenarios that they are likely to encounter when implementing the RH subaccounts.

Teaching each unit

The manual recommends that each unit begin with an interactive lecture aided by the PowerPoint slides, followed by the trainees doing the exercise(s), followed by a review of the exercise answers and group discussion.

I Materials needed for the training

Participant Manual:

- Binders
- PowerPoint handouts (two per page)
- Handouts copies
- Designed labels for cover of binder and binder spine
- Dividers with pockets
  (number of needed dividers = number of days of training-1)
- Copy of agenda
- Copy of participant list

Additional participant materials:

- Calculators
- Pencils
- Pens
- Note pads for participants

General training materials:

- Markers and flip charts and flip chart stands for documenting discussions and exercises
- LCD projector for PowerPoint presentations
- Name tags
- Masking tape
- Hole puncher
- Stapler
- Participant certificates
- Post-it notes
- Extra packets of paper (copy machine, computer internet rentals)

Timeframe for the workshop

Past workshops show that approximately three and a half days is an optimal amount of time for teaching the RH subaccounts methodology. It is recommended that the RH methodology be incorporated into the general NHA training which would then require five to seven days to teach all the units. The exact timeframe depends on the participants' prior knowledge of the NHA methodology, their learning styles, and the size of the class.

Two sample training agendas are included: one for an in-country workshop teaching RH subaccounts methodology alone, and the other for an in-country workshop teaching both the general NHA methodology and the RH subaccounts methodology together.

The trainer should note that the sample agendas do not teach the units in the order they are arranged in Module 1, i.e., according to the chronology of the NHA process. As an example of the flexibility of the NHA curriculum, they are arranged according to the needs, interests, and prior level of knowledge of the participants.

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Participant Information Sheet

1. What NHA and/or RH topics are you most interested in learning? Please check all that apply.

- ☐ Overall conceptual RH and NHA framework
- ☐ Planning for RH and NHA
- ☐ Understanding the main components
- ☐ Financing sources
- ☐ Financing agents
- ☐ Uses
- ☐ Classifications and boundaries
- ☐ Detailed analysis of the tables/matrices
- ☐ Identifying sources of information for data (data collection)
- ☐ Identifying data gaps and overcoming them
- ☐ Filling in the tables
- ☐ Policy impact
- ☐ Institutionalization

2. What do you know about NHA and the RH subaccounts? Please explain briefly the extent of your knowledge.

3. What is your area of work expertise (e.g., government accounting, health financing, epidemiology, medicine)?

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Sample Agendas

Sample Agenda
General NHA with RH Subaccounts Training

This sample agenda is for 5 days. This timeline might need to be extended if the trainer does additional presentations, for example, on other NHA subaccounts.

Day-1

9:00 – 9:30 am	Introduction and Pre-Test Objectives of the training: Review of agenda
9:30 – 10:30 am	Conceptual Overview of NHA ◆ Why NHA is necessary? o National perspective: Policy purposes o International perspective: standardized international comparability ◆ Definitions and Purpose ◆ Outline the tables
10:30 – 11:00 am	Tea and coffee break
11:00 – 12:00 pm	Policy use of NHA ◆ Policy "impact" of NHA around the world ◆ Interpreting NHA results *Includes group exercises*
12:00 – 1:00 pm	Lunch break
1:00 – 2:00 pm	Continuation of policy exercises (report back and discussion)
2:00 – 2:30 pm	Tea and coffee break
2:30 – 5:00 pm	Policy design of country's NHA presentation (presentations provided by country participants) ◆ Findings from the launch conference of stakeholders (should take place before training) ◆ How the country's NHA will be designed to accommodate those policy priorities ◆ Role of the steering committee: keeping them informed

Day-2

9:00 – 10:30 am	Concepts of expenditures ◆ What constitutes "expenditure"? ◆ What are the boundaries of health expenditures? ◆ Criteria for determining boundaries ◆ Space boundaries ◆ Functional boundaries ◆ Time boundaries ◆ Functional definitions of health *Includes group exercises*
10:30 – 11:00 am	Tea and coffee break
11:00 – 11:30 pm	Continuation of expenditure boundary exercises (report back and discussion)
11:30 – 12:30 pm	ICHA and the flexibility afforded by NHA
12:30 – 1:30 pm	Lunch break
1:30 – 3:00 pm	Classifying financing sources and financing agents *Includes exercises*
3:00 – 3:15 pm	Tea and coffee break
3:30 – 4:45 pm	Classifying Providers and functions *Includes exercises*

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Day-3

9:00 – 10:00 am	Collection of Data ◆ Sources (advantages and disadvantages) ◆ Primary and secondary sources ◆ Elements to be included in some surveys
10:00 – 10:30 am	Tea and coffee break
10:30 – 12:30 am	Developing the country's data plan
12:30 – 1:30 pm	Lunch break
1:30 – 3:00 pm	Organizing and interpreting the data for filling in the NHA tables ◆ General approach to filling in the matrices ◆ Steps to populating the FS x HF matrix ◆ Steps to populating the HF x HP matrix ◆ Resolving Data Conflicts ◆ Avoiding Double Counting
3:00 – 3:30 pm	Tea and coffee break
3:30 – 5:00 pm	Susmania case study: Setting the context for Susmania and filling in the FS x FA table

Day-4

9:00 – 10:00 am	Susmania case study: Interpreting the data for the HF x HP table
10:30 – 11:00 am	Tea and coffee break
11:00 – 12:30 pm	Susmania case study: Filling in the HF x Func and HP x Func tables
12:30 – 1:30 pm	Lunch break
1:30 – 3:00 pm	Susmania case study: Filling in the FA x Func and HP x Func tables
3:00 – 3:30 pm	Tea and coffee break
3:30 – 5:00 pm	Institutionalization of NHA ◆ Necessary steps for institutionalization ◆ How to integrate NHA into the national Health Information System ◆ Systemizing the procedures for data collection ◆ What is country doing for institutionalization

Day-5

9:00 – 9.30 am	How subaccounts fit into overall NHA framework – examples from other countries
9:30 – 10:15 am	Policy motivation for RH subaccounts? *Open discussion – the facilitator should record participants responses on flip chart.*
10:15 – 10:45 am	Break
10:45 – 12:30 pm	Introductions to concepts of RH specific expenditure definitions and boundaries *Open discussion on overlapping expenditures with other subaccounts – CH, HIV/AIDS, TB etc – record responses on flip chart*
12:30 – 1:30 pm	Lunch break
1:30 – 3:00 pm	RH Subanalysis – Classification – Presentation for 30 minutes *Exercise – List and assign ICHA codes to all RH relevant Sources FA, HF, and HC in your country (25 mins for exercise, and 10 mins for report out on the exercise)*
3:00 – 3:15 pm	Break
3:15 – 3:45	Data collection approach and planning for it (secondary and primary data collection)
3:45 – 4.45 pm	Data analysis considerations *Exercise - Ovaria case study*
4:45 – 5:00pm	Training evaluation and Distribution of certificates

Sample Agenda RH Subaccounts Training

This sample agenda is for 3-4 days. The duration of the subaccounts training depends on how familiar the participants are with the general NHA methodology. If they are familiar with general NHA methodology – a refresher on Day 1 of the training may be sufficient, if not, then consider spending 1.5-2 days on general NHA training first. This sample agenda is assuming the participants are familiar with NHA.

Day-1

9:00 – 9:30 am	Introduction and Pre-Test Objectives of the training: Review of agenda
9:30 – 10:30 am	General concept of NHA, its methodology, and its use as a policy tool
10:30 – 10:45 pm	Break
10:45 -12.00	Progress of NHA in your country – Discussion of NHA results from past rounds
12:00 – 1:00 pm	Lunch break
1:00 – 2:00 pm	Policy motivation for conducting RH subaccounts in your country – *(Open discussion led by the facilitator. Record participant responses on a flip-chart)*
2:00 – 2:45 pm	Introduction to RH subaccounts ◆ How subaccounts fit into overall NHA framework ◆ RH subaccounts ◆ Some global RH examples and policy stories
2:45 – 3:00 pm	Break
3:00 – 4:00 pm	Boundaries of RH subaccounts ◆ ICPD definitions, ◆ scope of RH subaccounts ◆ overlap with other subaccounts such as HIV/AIDS, CH subaccounts
4:00 – 5:00 pm	Exercises on boundaries

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Day-2

9:00 – 10:30 am	ICHA classification generic approach ◆ ICHA codes in the RH context ◆ Application of ICHA codes your specific country context ◆ Exercises
10:30 – 10:45 am	Break
10:45 – 12:00	Reproductive health subaccount tables
12:00 – 1:00 pm	Lunch
1:00 – 2:00 pm	Data collection approach ◆ Data assessment and identifying data gaps ◆ What secondary/existing data are available ◆ Primary data collection
2:00 – 3:00 pm	Exercises on data collection
3:00 – 3:15 pm	Break
3:15 – 4:30 pm	Develop a data collection plan

Day-3

9:00 – 10:15 am	Data analysis issues ◆ Boundary related data analysis issues (overlapping expenditures) ◆ Commodity related issues ◆ Non-targeted expenditures
10:15 – 10:30 am	Break
10:30 – 12:30 pm	Ovaria case study – applying to practical example the data analysis approach
12:30 – 1:30	Lunch
1:30 – 3:30 pm	Implementation process ◆ Identifying stakeholders ◆ Setting up the Steering committee ◆ RH subaccounts team structure ◆ Institutionalization
3:30-3:45 pm	Break
3:45 – 4:15 pm	Next steps to carry out the subaccounts
4:15 – 5:00 pm	Closing remarks ◆ Training evaluation ◆ Distribution of certificates

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Pre-test for Subaccounts Training

Directions: Please answer the following questions. Outline or bullet form is acceptable.

Unit 1: Introduction to RH Subaccounts

Question 1

Describe the concept of a RH subaccount?

Answer

Question 2

What is the purpose of the subaccount?

Answer

Unit 2: Definitions and Boundaries for the RH Subaccounts

Question 1

How should the scope of a subaccounts be determined- based on what criteria?

Answer

Question 2

Should expenses incurred on the treatment of ovarian cancer by an individual in another country be included in their RH subaccounts?

Answer

Unit 3: Concept of Classifications for Reproductive Health Subaccounts

Question 1

Why is it important to adopt ICHA classification system?

Answer

Question 2

How would you classify fertility treatment at a traditional healer?

Answer

Question

Money is given by an NGO to the Family Planning Program at MOH – which cell would you include this expenditure within the HF x HP table? (e.g. HF.1xHP.1.1)

Answer

Unit 5: Data Collection Approach

Question

List 4 major categories of data sources and the order in which they should be pursued when determining a data collection plan.

Answer

Unit 6: Data Analysis Approach

A NGO using donor funds procures condoms for $200, sells it to a wholeseller at $100, who sells it to a semi-wholeseller at $125, who then sells it to the pharmacy at $150, who finally sells it to the consumer at $175.

Question 1

What would be included in the NHA as the donor spending for condoms?

Answer

Question 2

What would be included in the NHA as household spending for condoms at a private pharmacy?

Answer

I

Unit 7: Implementation Process for Reproductive Health Subaccounts

Question 1

What is the role of the steering committee in the process of subaccounts implementation?

Answer

Post-test for Subaccounts Training

I

Directions: Please answer the following questions. Outline or bullet form is acceptable.

Unit 1: Introduction to RH Subaccounts

Question 1

Describe the concept of a RH subaccount?

Answer

Question 2

What is the purpose of the subaccount?

Answer

I

Unit 2: Definitions and Boundaries for the RH Subaccounts

Question 1

How should the scope of a subaccounts be determined- based on what criteria?

Answer

Question 2

Should expenses incurred on the treatment of ovarian cancer by an individual in another country be included in their RH subaccounts?

Answer

Unit 3: Concept of Classifications for Reproductive Health Subaccounts

Question 1

Why is it important to adopt ICHA classification system?

Answer

Question 2

How would you classify fertility treatment at a traditional healer?

Answer

Unit 4: Setting up and Reading the RH Tables

Question

Money is given by an NGO to the Family Planning Program at MOH – which cell would you include this expenditure within the HF x HP table? (e.g. HF.1xHP.1.1)

Answer

Unit 5: Data Collection Approach

Question

List 4 major categories of data sources and the order in which they should be pursued when determining a data collection plan.

Answer

Unit 6: Data Analysis Approach

A NGO using donor funds procures condoms for $200, sells it to a wholeseller at $100, who sells it to a semi-wholeseller at $125, who then sells it to the pharmacy at $150, who finally sells it to the consumer at $175.

Question 1

What would be included in the NHA as the donor spending for condoms?

Answer

Question 2

What would be included in the NHA as household spending for condoms at a private pharmacy?

Answer

Unit 7: Implementation Process for Reproductive Health Subaccounts

Question 1

What is the role of the steering committee in the process of subaccounts implementation?

Answer

I

Answer Key - Pre and Post-test for Reproductive Health Subaccounts Training

Directions: Please answer the following questions. Outline or bullet form is acceptable.

Unit 1: Introduction to RH Subaccounts

Question 1

Describe the concept of a RH subaccount?

Answer

Tracks expenditures on reproductive health care in keeping with the NHA framework. Aims to be comprehensive–inclusive of public, private, and donor spending.

Question 2

What is the purpose of the subaccount?

Answer

To be used as a policy tool. To inform the policy process.

Unit 2: Definitions and Boundaries for the RH Subaccounts

Question 1

How should the scope of a subaccounts be determined- based on what criteria?

Answer

- When primary purpose of expenditure is: a) to promote reproductive health and b) to prevent/treat RH associated illnesses, and
- national policy context
- international recommendations
- 2% rule- include an expenditure if it is likely to be more than 2% of the THE.

Question 2

Should expenses incurred on the treatment of ovarian cancer by an individual in another country be included in their RH subaccounts?

Answer

No – it is outside the geographical boundary of the country where the treatment was received, but it should be included in the subaccounts of the individual's native country (where he/she resides).

Unit 3: Concept of Classifications for Reproductive Health Subaccounts

Question 1

Why is it important to adopt ICHA classification system?

Answer

It describes the principal dimensions of health expenditures– in terms of categories with common characteristics and there by standardizing the definitions of various types of health expenditures. Also, it is an internationally accepted tool and therefore allows for international comparability

Question 2

How would you classify fertility treatment at a traditional healer?

Answer

HC. 1.3 OP care

Unit 4: Setting up and Reading the RH Tables

Question

Money is given by an NGO to the Family Planning Program at MOH – which cell would you include this expenditure within the HF x HP table? (e.g. HF.1xHP.1.1)

Answer

HF 2.4 x HP 2.5

Unit 5: Data Collection Approach

Question

List 4 major categories of data sources and the order in which they should be pursued when determining a data collection plan.

Answer

1. Existing information systems
2. Secondary data
3. Ongoing surveys- to which rider questions can be added
4. Developing RH subaccounts-specific surveys

Unit 6: Data Analysis Approach

An NGO using donor funds procures condoms for $200, sells it to a wholeseller at $100, who sells it to a semi-wholeseller at $125, who then sells it to the pharmacy at $150, who finally sells it to the consumer at $175.

Question 1

What would be included in the NHA as the donor spending for condoms?

Answer

$200-100 = $100

Question 2

What would be included in the NHA as HH spending for condoms at a private pharmacy?

Answer

$175

I Unit 7: Implementation Process for Reproductive Health Subaccounts

Question 1

What is the role of the steering committee in the process of subaccounts implementation?

Answer

- Meet regularly with technical team
- Help frame policy focus of subaccounts
- Facilitate data retrieval- particularly from "hard to get" data sources
- Provide guidance for the process
- Review the report and help interpret the findings for policy purposes
- By supporting the RH subaccounts, the SC can also facilitate the use of RH subaccounts for policy discussions.

I Evaluation of the Reproductive Health Subaccounts Training

Units	Which Units did you find MOST useful?	Why? Which Units need improvement? What are your suggestions?
Introduction to RH Subaccounts		
Definitions and boundaries for the RH Subaccounts		
Concept of Classifications for RH Subaccounts		
Possible Classifications for RH subaccounts HC, HP, HF, and FS Dimentions		
Setting up and Reading the RH Tables		

Units	Which Units did you find MOST useful?	Why? Which Units need improvement? What are your suggestions?
Data Collection Approach		
Data Analysis Approach		
RH-Specific Data Analysis Issues		
Data Analysis Case Study		
Implementation Process for RH Subaccounts		

1

Unit 1

Introduction to Reproductive Health Subaccounts

Time

360 minutes

Learning Objectives

At the end of this Unit partcipants will:

- Understand the importance of RH in achieving the Millennium Development Goals
  - Recognize the need for national tracking of resources on RH
- Understand the global burden of RH associated illnesses
- Learn the concept of "National Health Accounts" and "Subaccounts"
  - Understand the concept of "RH Subaccounts"
- Be introduced to some country examples of RH Subaccounts findings

Content

- Slide presentation
- Exercises
- Answers
- Handout

Exercises

- Discussion questions

References

PHR*plus*. 2002. *Issues and Results: Using National Health Accounts to Make Policy Decisions.* Bethesda, MD: PHR*plus,* Abt Associates Inc.

PHR*plus*. 2002. *Informing the Policy Process: Global Experiences of NHA.* Bethesda, MD: PHR*plus,* Abt Associates Inc. (September)

Rannan-Eliya, R.P., P.A. Berman, and A. Somanathan. 1997. *Health Accounting: A Comparison of the System of National Accounts and National Health Accounts Approaches.* Special Initiative Report 4. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc. (On NHA Resources CD)

World Health Organization, World Bank, and United States Agency for International Development. 2003. *Guide to producing national health accounts with special application for low-income and middle-income countries*. Geneva: World Health Organization.

World Health Organization, 2000. *The World Health Report 2000; Health Systems: Improving Performance,* Chapters 4, 5. Geneva, Switzerland: WHO. (On NHA Resources CD)

Unit 1 - Slide Presentation

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Unit 1:
Introduction to Reproductive Health (RH) Subaccounts

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2

Learning Objectives

At the end of this Unit, participants will:

- Understand the importance of RH in achieving the Millennium Development Goals
  - Recognize the need for national tracking of resources on RH
- Understand the global burden of RH associated illnesses
- Learn the concept of "National Health Accounts" and "Subaccounts"
  - Understand the concept of "RH Subaccounts"
- Be introduced to some country examples of RH subaccounts findings

3

The importance of RH in achieving the MDGs

- Reproductive ill health undermines development and quality of life and places heavy burdens on families and communities

  "…the eradication of extreme poverty and hunger, cannot be achieved, if questions of population and reproductive health are not squarely addressed."

  Kofi Annan, United Nations Sec. General, 2002

4

World response to RH

- Since early 1990's there have been continuous efforts to increase access to RH services globally through:
  - The International Conference on Population and Development (ICPD) held in Cairo in 1995- identified RH activities and costed them for lesser developed countries and led to recommendations for a "Costed Population Package"
  - Five years after ICPD in Cairo (known as ICPD+5), a target of universal access to quality RH services by 2015 was set by the international community
  - Reduction of maternal mortality as one of the MDG targets

5

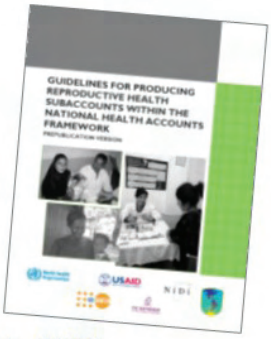
Need for RH expenditure data

- Competing needs for scarce health care resources means limited resources for RH services and goods despite being an area of both national and international priority
- Given limited resources
  - Imperative that policy decisions for delivery of RH services and goods be based on good information to get best outcome
- Expenditure data can help guide allocation of limited resources among alternative uses e.g. intervention mix

6

Development of a methodology for RH resource tracking

- The methodology
  - Approach: Aims to be internationally viable-in accordance with the National Health Accounts approach
  - Sponsors:
    - US Agency for International Development (USAID)/Partners for Health Reform (PHR)plus and USAID/Health Systems 20/20 project, World Health Organization (WHO), Netherlands Interdisciplinary Demographic Institute (NIDI)
  - Pilot Experience: The methodology incorporates lessons learned from Rwanda, Malawi, Ethiopia, Morocco, India (Karnataka State), Jordan, and Mexico



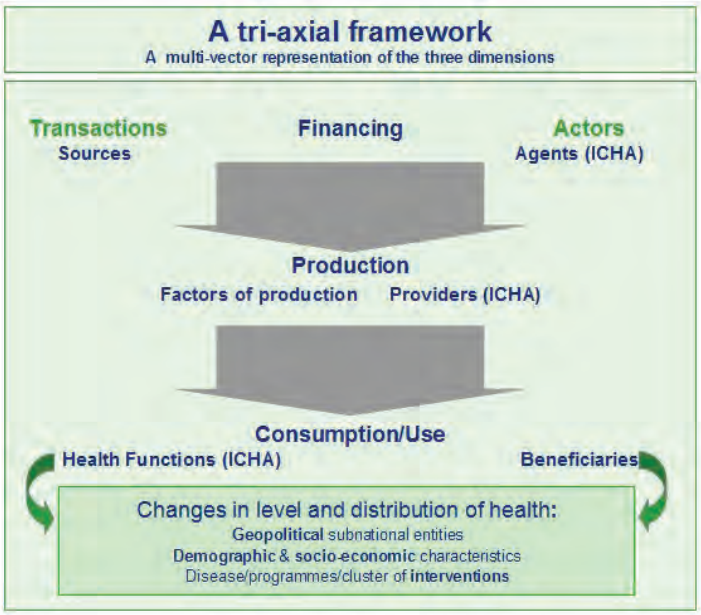
7

What is National Health Accounts?

- Framework for measuring amounts and flows of national health spending for a given year
  - between four levels (at a minimum)
    - Financing Sources (originators of funds) e.g. MoF, Donors
    - Financing Agents (managers of funds) e.g. MoH, Insurance
    - Providers (deliver services) e.g. Pharmacies, hospitals
    - Functions (health service/product) e.g. outpatient care, drugs bought at independent pharmacies/shops
  - organizes information in a standard set of 2 crossclassified tables
- Includes public, private, and donor health spending
- Designed to address policy concerns

8

Flow of Resources



9

How is NHA different from a cost analysis

- NHA tracks resource flows within a health system and measures the consumption of health goods and services in a country. It also captures who pays for them
- Cost analysis looks at the input mix needed to produce one unit of output (health goods or services)

10

Illustrative NHA Tables

1)	*Financing Sources*				
Financing Agents	FS.1.1.1 Central Gov. (MoF)	FS.3. Rest of the World (Donors)	FS.2.1 Employer Funds	FS.2.2 Household Funds	**TOTALS**
HF.1.1.1.1 Ministry of Health	A	B			**A +B**
HF.1.1.1.2 Ministry of Education	C				**C**
HF.2.2 Private Insurance Enterprises			D	E	**D +E**
HF. 2.3 Private households' out-of-pocket				F*	**F***
TOTALS					**G**

2)	*Financing Agents*				
Providers	HF.1.1.1.1 MoH	HF.1.1.1.2 MoE	HF.2.2 Private Insurance Enterprises	HF.2.3 Households	**TOTALS**
HP.1.1.1 Public General Hospitals	W		X		
HP.1.1.2 Private General Hospitals		C		F	
HP.3.4.5.1 Public Outpatient Clinics			Y		
TOTALS	**W=A+B**	**C**	**X+Y= D+E**	**F**	**G**
* direct transfer of payment					

11

Why the link with NHA?

- NHA is globally used and its approach allows for international comparison
- Conducted in 100+ countries
  - Many of which are beginning to implement NHA as part of routine government activities
    - Potential for routine estimation of RH spending
    - Will build upon existing country capacities
- RH expenditures can be placed in context of overall health
  - As a "Subaccounts" (subcomponent) of general NHA

12

Subaccounts

- Additional review of spending patterns for the delivery of a particular set of health care services, such as
  - disease-specific services (e.g. Malaria, HIV)
  - Or intervention clusters (e.g. reproductive health services, child health care)
  - To support decisions at programme level
- Generally conducted in tandem with general NHA
  - Can be "piggy-backed" onto general NHA data collection process – cost saving
- Included as separate chapters within the general NHA report
- Policy Purpose
  - Provide stakeholders with comprehensive review of RH flow of funds
  - Assess the relative financial priority of RH in health system
  - Serve as both an advocacy and monitoring tool – supporting evidence-based approach to the policy process

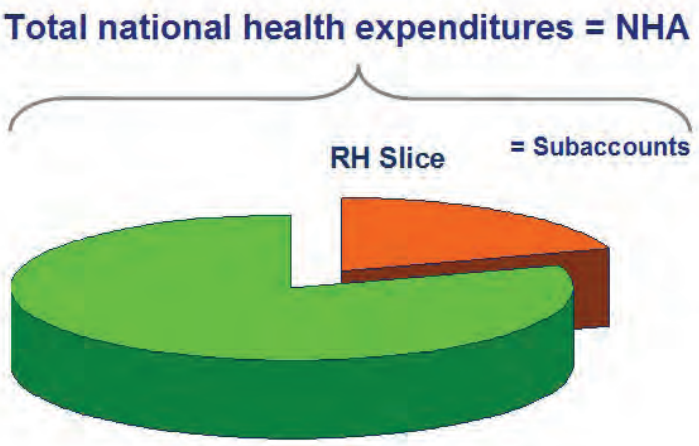
13

Indicators for RH subaccount

General Indicators	■ Total RH expenditures (and to the extent possible, expenditure on RH by region) ■ Total RH expenditures by RH functional category ■ RH expenditures per woman/man of reproductive age ■ RH expenditures as a % of GDP ■ RH expenditures as a percentage of total overall health spending
Financing sources indicators	■ Public contribution as % of Total Health Expenditure for RH (THE_{RH}) ■ Public RH contribution as a % of overall public spending on health ■ Private contribution (by households and other private entities) as % of THE_{RH} ■ Donor contribution as a % of THE_{RH} ■ Linking of Financing sources to their end uses/NHA functional area/RH functional category: ■ e.g. % of curative care financed by donors versus households versus the government ■ e.g. % of maternal health services financed by donors versus households.
Household expenditure indicators	■ Total household spending as % of THE_{RH} ■ Out-of-pocket (OOP) spending as % of THE_{RH} ■ OOP spending by RH functional category (see below). ■ OOP spending per woman of reproductive age ■ OOP spending on RH as a share of overall OOP spending on health.
Financial Agent Indicators	■ Percentage of RH funds managed by ■ the Ministry of Health and other public entities ■ NGOs and donors ■ Directly by households (through OOP) ■ Health insurance contributions ■ By RH functional category
Provider indicators	■ Provider expenditure as % of THE_{RH} ■ By ownership (public and private) ■ By facility (hospital, health center, shops etc)
Functional Indicators	■ Curative Care as % of THE_{RH} ■ Inpatient curative care as a % of THE_{RH} ■ Outpatient curative care as a % of THE_{RH} ■ Prevention and Public Health programs as % of THE_{RH} ■ Health Administration as % of THE_{RH}
RH functional categories	■ Maternal health services (including prenatal, postnatal, and delivery proportions) as % of THE_{RH} ■ Expenditure per delivery by type of facility ■ Breakdown of maternal health expenditures by Financing Sources (e.g. % of maternal health expenditures financed by households). ■ Family planning as % of THE_{RH} ■ Abortion as a % of THE_{RH} ■ STI, cancers, reproductive tract infections, and other gynecological morbidities as a % of THE_{RH} ■ Promoting sexual health (including the elimination of harmful sexual practices) as a % of THE_{RH} ■ Other prevention and public health programs as a % of THE_{RH}, STI expenditures as % of THE_{RH} ■ Administration as a % of THE_{RH} ■ 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

14

Subaccounts – a piece of the health pie



15

RH Subaccounts within context of general health care

Example of findings from 2002 Rwanda RH Subaccounts (1)

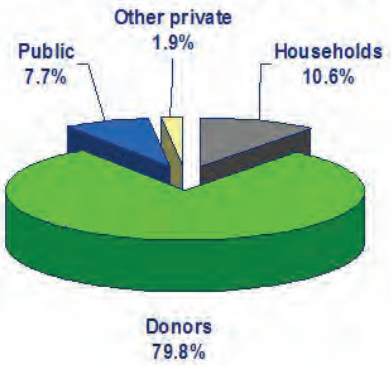
Reproductive Health (RH) spending as a percentage of total health expenditures in Rwanda, 2002

16

Who is funding RH in Rwanda?

Example of findings from 2002 Rwanda RH Subaccounts (2)

Donors finance the majority of RH expenditures

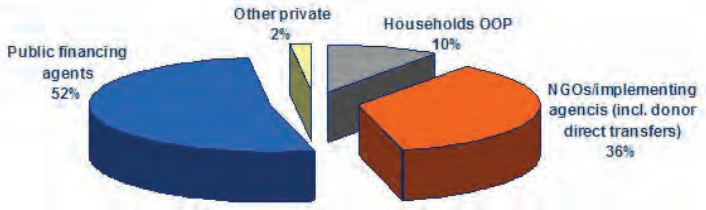


17

Who manages RH funds?

Example of findings from 2002 Rwanda RH Subaccounts (3)

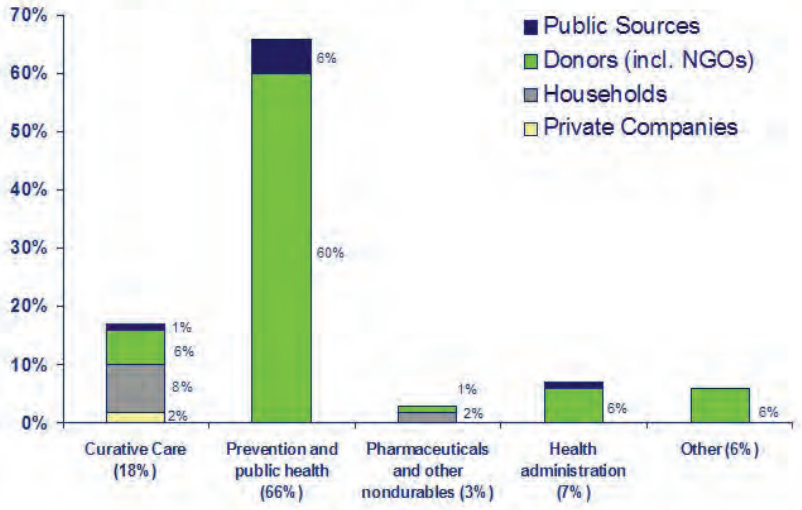
Principal managers of RH funds are still public entities



18

What types of RH services are being funded and by whom?

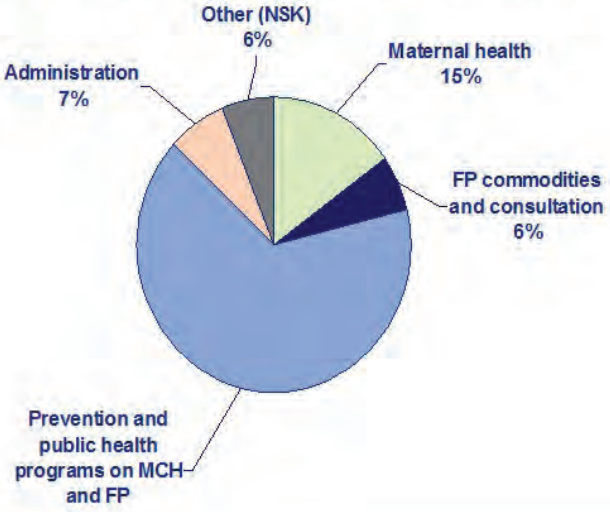
Example of findings from 2002 Rwanda RH Subaccounts (4)



19

Breakdown by RH categories

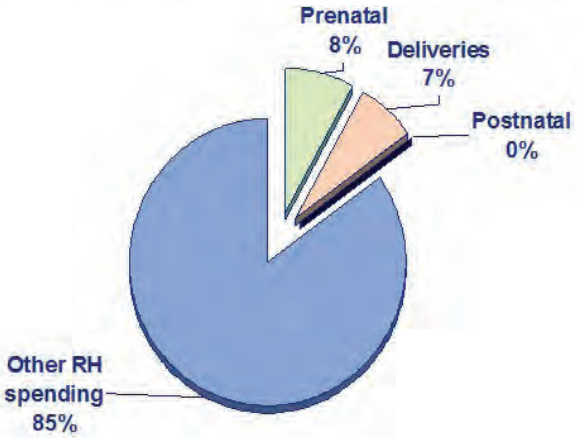
Example of findings from 2002 Rwanda RH Subaccounts (5)



20

Maternal health care as a proportion of RH spending, excluding programs

Example of findings from 2002 Rwanda RH Subaccounts (6)



21

Conclusion of RH subaccounts

Example of findings from 2002 Rwanda RH Subaccounts (7)

- Dependence on donors to finance RH
- Low government contribution to RH
  - In fact, households finance more than the government
- Households contribute close to half of all curative RH expenditures
  - Donor expenditures are primarily targeted for prevention and public health programs

22

RH Policy questions

- How much is spent on RH care? What is its share of total health expenditures?
- What is the reliance on donors for RH services and commodities? What share of donor health funds are targeted for RH?
- What share of public health funds is spent on RH care?
- What is the financial burden on households to pay for RH care? How does this compare to utilization rates of services/ contraceptive commodities?
- What is the proportion of out of pocket expenditures with respect to other private expenditures
- Are expenditures in line with national plans on resource needs/estimates for RH?

23

RH Policy questions - Cont'd

- What role does the private sector play?
- What types of services are financed by RH funds?
- Who provides what RH services and where?
- Who benefits from RH spending?
- How does financing of RH services compare between countries?
- What are the implications of different health-financing policy options on the mobilization and allocation of resources for RH?

24

What issues does RH subaccounts not address?

- Does not assess effectiveness of expenditures or provide comprehensive data for long term projection
- High level of detail is difficult to capture for many low income countries
- Does not measure expenditures on indirect activities (such as loss of income due to illness etc.)

25

Take home message

- RH is very important achieving the MDGs
- Concept of NHA methodology – adapted to capture RH specific expenditures
- Expenditures on key program components can be monitored
- RH expenditures can be measured in the context of overall health expenditures
- Policy decisions for RH service delivery should be based on good information to get best outcome
- Expenditure data can help guide allocation of limited resources among alternative uses (e.g. intervention mix)

26

Food for thought; Discussion questions

- Country participants – what specific RH related policy issues come to mind in your respective countries?
- What other RH financial indicators would you like your RH subaccounts to track on a regular basis?
- For the RH Subaccounts – what type of information should be collected? Expenditures or Budgetary? Why?*
- What happens when international organizations use inaccurate or non-standard expenditure information for international comparisons?*

27

Policy impact stories

- **Ethiopia**

  Result: All commodity procurement costs are largely financed by donors.

  Policy impact: Prompted policy discussions on how to increase government funding/support

- **Rwanda**

  Result: High out of pocket expenditures for contraceptives

  Policy impact: Facilitated a discussion among all major stakeholders to identify new financiers for commodities

28

Policy impact stories - Cont'd

- **Rwanda 2002**

  Results: 80 percent of RH expenditures borne by donor

  Policy impact: Government then made a commitment to increase domestic support. This increase in govt. support is evident in 2006 results. In this case, the RH subaccounts were used as a policy monitoring and evaluation tool.

- **Malawi**

  Results: High expenditures and low health outcomes when compared to other countries in similar socio-economic levels

  Policy impact: Has prompted govt. into looking at how funds are spent and reinforced the need for new performance based financing mechanisms

29

Policy impact stories - Cont'd

- **Jordan**
  A country committed to decreasing the population growth rate, the public sector contributes only 38% and bulk of the expenditures (46%) are borne by households raising serious equity issues in accessing care
- **RH subaccounts were adopted by African Ministers of Health (Maputo, Sept 2006) as needed policy tool to advocate for increased RH resources** –
  "It is recommended that health ministries use NHAs and SRH subaccounts as tools in their policy dialogues. They should institutionalize NHAs and SRH subaccounts to ensure systematic tracking of expenditures, improving not only efficiency in allocating funds but advocacy for more resources for health. Countries and donors should cooperate to develop national capacity to undertake NHAs and SRH sub-accounts"

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Thank you

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Unit 1 - Exercises

Discussion questions

Question 1

For the RH Subaccounts – what type of information should be collected? Expenditures or Budgetary? Why?

Answer

Question 2

What happens when international organizations use inaccurate or non-standard expenditure information for international comparisons?

Answer

Unit 1 - Answers

Discussion questions

Question 1

For the RH Subaccounts – what type of information should be collected? Expenditures or Budgetary? Why?

Answer

Budgeted funds may not be spent according to plan and thus may not reflect how much money actually goes into the health sector.

Budget info is collected only for major institutions, not other key players e.g. households.

Expenditure data can reflect financial cost of major disease burdens or epidemics, whereas budget info merely estimates future needs. Ultimately, the budgeting process can benefit from knowing how much has already been spent to deliver health services.

Question 2

What happens when international organizations use inaccurate or non-standard expenditure information for international comparisons?

Answer

Often donors use the internationally published estimates in their own decision-making processes regarding how much to allocate to which country and which sector. Inaccurate estimates may lead to misguided decisions regarding donor funding allocation decisions.

Estimates collected using different methodologies hinder cross-country comparisons of expenditures. As a result, policymakers are unable to compare their country's spending patterns with those of other countries; useful lessons learned in one country that spends less on health but has better health outcomes may not be shared with other countries.

In addition to limiting policymakers, the inability to do cross-country comparison has adverse implications for international researchers and their efforts to offer countries sound technical assistance to improve health system performance.

Question 3

Country participants – what specific RH related policy issues come to mind in your respective countries? Discussion – for example – have countries developed their national strategic RH/FP plans – what are the targets, how much resources are allocated for them.

Unit 1 - Handout
Proposed Indicators for the Reproductive Health Subaccount

Purpose of needed information	Examples of the types of data needed
General Indicators	☐ Total RH expenditures (and to the extent possible, expenditure on RH by region) ☐ Total RH expenditures by RH functional category ☐ RH expenditures per woman/man of reproductive age ☐ RH expenditures as a % of GDP ☐ RH expenditures as a percentage of total overall health spending
Financing sources indicators	☐ Public contribution as % of Total Health Expenditure for RH (THERH) ☐ Public RH contribution as a % of overall public spending on health ☐ Private contribution (by households and other private entities) as % of THERH ☐ Donor contribution as a % of THERH ☐ Linking of Financing sources to their end uses/ NHA functional area/ RH functional category: • e.g. % of curative care financed by donors versus households versus the government • e.g. % of maternal health services financed by donors versus households
Household expenditure indicators	☐ Total household spending as % of THERH ☐ Out-of-pocket (OOP) spending as % of THERH ☐ OOP spending by RH functional category (see below). ☐ OOP spending per woman of reproductive age ☐ OOP spending on RH as a share of overall OOP spending on health.
Financial Agent Indicators	☐ % of RH funds managed by • the Ministry of Health and other public entities • NGOs and donors • Directly by households (through OOP) • Health insurance contributions o By RH functional category
Provider indicators	☐ Provider expenditure as % of THERH • By ownership (public and private) • By facility (hospital, health center, shops etc)

Purpose of needed information	Examples of the types of data needed
Functional Indicators	☐ Curative Care as % of THERH • Inpatient curative care as a % of THERH • Outpatient curative care as a % of THERH ☐ Prevention and Public Health programs as % of THERH ☐ Health Administration as % of THERH
RH functional categories	☐ Maternal health services (including prenatal, postnatal, and delivery proportions) as % of THERH • Expenditure per delivery by type of facility • Breakdown of maternal health expenditures by Financing Sources (e.g. % of maternal health expenditures financed by households). ☐ Family planning as % of THERH ☐ Abortion as a % of THERH ☐ STI, cancers, reproductive tract infections, and other gynecological morbidities as a % of THERH ☐ Promoting sexual health (including the elimination of harmful sexual practices) as a % of THERH ☐ Other prevention and public health programs as a % of THERH ☐ STI expenditures as % of THERH ☐ Administration as a % of THERH ☐ 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 delivering RH6 health care)

Note, household expenditure is not necessarily the same as out-of-pocket expenditure. Household expenditure includes direct and indirect payments to providers, including premiums given to insurance schemes. OOP expenditure only includes direct payments to providers.
Harmful sexual practices include female genital cutting, rape, incest, sexual trafficking, and sexual exploitation of minors

2

Unit 2

Definitions and Boundaries for the Reproductive Health Subaccounts

Time

60 minutes

Learning Objectives

- Be aware of the definition of RH expenditures
- Understand the scope of RH Subaccounts
- Comprehend the various boundary issues
  - Between health and health-related
  - With other subaccounts
  - With geography/space
  - With time
  - Potential national differences in relation to health accounting framework

Content

- Slide presentation
- Exercises
- Answers
- Handouts

Exercises

- Application exercises on boundaries

Unit 2 - Slide Presentation

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Unit 2:
Definitions and Boundaries for the RH Subaccounts

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Training Resources Group
Tulane University's School of Public Health

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2

Learning objectives

- Be aware of the definition of RH expenditures
- Understand the scope of RH subaccounts
  - Specifically, that which is included in a 1) Primary purpose 2) Local policy perspectives and international norms.
- Comprehend the various boundary issues
  - Between health and health-related
  - With other subaccounts
  - With geography/space
  - With time
  - Potential national differences in relation to health accounting framework

3

General NHA principles when determining the scope

- Should include health and health-related expenditures only
  - Focus on direct expenditures, not indirect or intangible
  - i.e. activities whose primary purpose is health restoration, maintenance, and improvement for the nation during a defined period of time
- Consider local policy relevance
  - When in doubt, include those expenditures that are a priority to policymakers
- Consider international recommendations
- The 2% threshold (rule of thumb)
  - Include an expenditure if it is likely more than 2% of total health expenditures

4

Background on RH subaccounts Boundaries

- What is RH?
- What is RH care?
  - See handout for definitions

5

Definition of RH expenditures

- Primary purpose Definition:
  - *if the primary purpose of the incurred expenditure is to restore, improve, and maintain reproductive health for the nation and for individuals during a defined period of time, then that expenditure should be included within the scope of a reproductive health subaccounts*
- Local policy perspectives and international norms
  - *if the activity under consideration falls outside the scope of the ICPD definition, its expenditure should be excluded at least for comparison purposes*

6

Scope of RH expenditures cont'd

Overlapping service	Subaccounts that could possibly include overlapping services with the RH subaccount			
	RH Subaccount	CH Subaccount	HIV/AIDS Subaccount	Malaria subaccount
STI services	X		X	
HIV/AIDS services	X		X	
PMTCT for HIV/AIDS	X		X	
Intermittent Preventive Therapy and Antimalarial chemoprophylaxis (given to pregnant mothers for malaria prevention)	X			X
Basic new born health care (in pre-natal period)	X	X		

7

Core Health Expenditures

- Core health includes
  - Personal care: treatment and rehabilitation
  - Medical good provision
  - Collective care: prevention and public health
  - Administrative and insurance
- Abbreviated by HC (described later in classifications unit)
- Includes those incurred (primary purpose):

  Primarily and entirely associated with RH care

8

Health Related Expenditures

- Abbreviated by HCR
- Includes those incurred (primary purpose):
  - Capital formation in facilities (laboratory facilities, drug storage system etc.) (HCR 1)
  - Formal training (degree based) of health personnel on RH related matters (HCR 2)
  - Research on RH (HCR 3)
    - Note however: guidelines suggest that "hands on training and research" particularly in clinical care settings should be included in THE.**
  - HCR. 5 Environmental Health

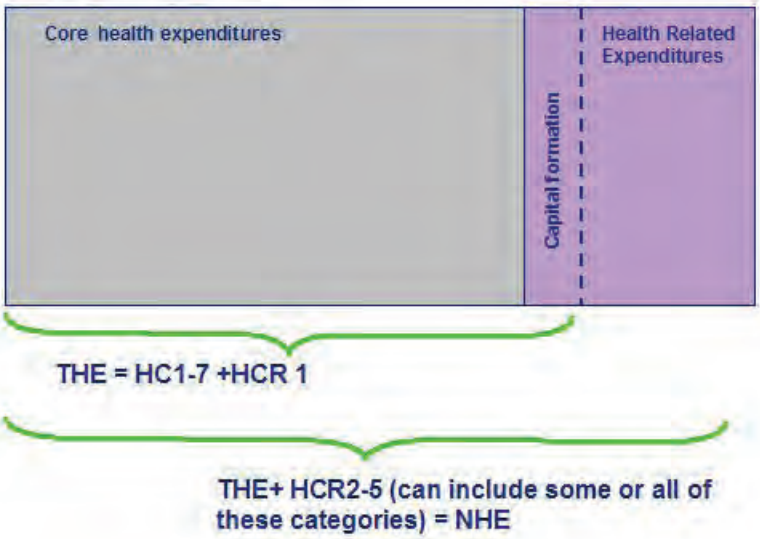
9

Addendum Item Expenditures

- RH activities that are principally 'non-health' in nature are referred to as addendum items or "below the National Health Expenditure (NHE) line" items
- Programs addressing gender-based violence, elimination of harmful sexual practices, sexual trafficking, and exploitation of minors

10

Possible total estimates for a RH Subaccounts



* THE used for international comparisons

11

Core health care activities

- Curative care – facility based or home based
  - Maternal health care – obstetric services
  - Family planning services – Sterilization or abortion for FP purposes
  - RH services – RTI diagnosis and treatment, RH related cancers etc.
- Ancillary services
  - Clinical labs
  - Diagnostic
  - Emergency transport and rescue
- Medical good dispensed
  - Prescribed medicines
  - Over the counter
  - Other medical non-durables

12

Core: Prevention and Public Health Services

Prevention and Public Health Services

- Maternal health; family planning, and counseling
  - Maternal health preventive program: - pre-post natal care, pregnancy related nutrition program, safe motherhood IEC/BCC programs
  - Family planning: - FP programs, infertility prevention, and referral programs
- Prevention of communicable diseases – be vigilant about overlapping with other subaccounts (HIV/AIDS)
  - For e.g. condom promotion for STI , IEC/BCC program
- Prevention of non-communicable diseases
  - For e.g. prevention of RTIs, RH related cancers and gynaecological morbidities, prevention of unsafe abortion, promotion of sexual health and rights etc.

13

Core: Health administration and insurance

- Government administration of health, coordination and policies (excluding social security)
  - Preparation of RH country strategies and plans
  - Formulation of policies and programs related to RH
  - Coordination with program partners and other institutions providing support to RH
  - General administration: linked to the direct use and management of resources
    - Purchases, transportation, salary payments, supervision etc.
  - Provide consumer protection and quality assurance services
  - RH surveillance and monitoring
- Administration, operation of social security funds that cover RH services

14

Core: Health administration and insurance contd.

- Administration of health insurance programs
  - Social insurance
  - Other private insurance

15

Health RELATED: Research

- Research
  - Development of new tools for RH
  - Studies on epidemiology
  - Development of better interventions
  - Studies on population health care seeking behavior-Operations research
    - use of antenatal and delivery services
    - Use of different contraceptives
  - Development of RH-related training curriculum and materials

16

Health RELATED: Capital formation

- Capital Formation
  - upgrading of laboratory equipment in health facilities – for example – equipment in OB-GYN clinics
  - included in THE

17

Space Boundary

- Includes those expenditures for prevention and treatment that benefit country residents
  - Whether made in-country or
  - Outside of the country
- Excludes expenditures by foreigners on RH
  - Difficult to exclude in practice
    - However, NHA team members are encouraged to think about possible ways of excluding this based on the type of data available in a given country

18

RH temporal boundary issue

- Procurement of contraceptive commodities from donors
  - Donors may provide two years worth of commodities in one shipment
  - Rather than including entire value, expenditure amount should be adjusted to reflect the value of commodities actually used that year
- Temporal spans of
  - "post-partum"
    - Only care to mother post-partum should be included
    - Post-partum period is six weeks post delivery
  - "newborn"
    - Should only be included if it is for services rendered to infants up to 28 days post birth (ICD-10) and if those services are part of routine or "well-baby" care
      - If there is a health problem with the infant, expenditures on services to address the condition should be in CHILD health

19

Take home message

- Ultimately, the scope depends on
  - primary purpose of expenditure
    - Is it to limit and/or space births? Or
    - Support and promote the limiting of births? Or
    - Or deliver healthy babies?
  - national policy context
  - international recommendations
  - 2% rule
- There may be overlaps between different subaccounts
  - Regardless, overlapping areas should be clearly identified

20

Application questions

- See the handout for exercises

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Thank you

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are available at www.healthsystems2020.org
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HEALTH SYSTEMS 2020

Unit 2 - Exercises

Question 2.1

If Nevaripine is administered to a pregnant woman to reduce the possibility of PMTCT would the expenditures be captured in RH subaccounts or HIV/AIDS subaccounts? Explain your answer.

Answer

Question 2.2

A breast-feeding campaign is launched, should the expenditures associated with this campaign be included in RH subaccounts or CH subaccounts?

Answer

Question 2.3

The added expenditures of a premature delivery that resulted from HIV/AIDS associated opportunistic infection of the mother. Should these expenditures be included in the RH subaccounts? Explain your answer.

Answer

Question 2.3a

Should in-kind contraceptive contributions from donors be included in RH subaccounts? If yes, how should they be captured in the RH NHA framework?

Answer

Question 2.3b

When household out of payments are made in kind for a service procured at the traditional healer, would these expenditures be included in the RH subaccounts, if yes, how?

Answer

Question 2.4

Donors spend and procure condoms in the year 2003. These condoms are given to the MoH that year for distribution; however, because of a backlog, they are not distributed to the facilities and subsequently not given to patients. Should the expenditures for those nets be included in the 2003-year's NHA estimations? Please explain your answer.

Answer

Question 2.5

Alia Al Qutub has a complicated pregnancy Her family takes her to overseas to a referral hospital in London currently Alia's family is paying for all expenses.

Answer

Question 2.5a

Should the RH subaccounts include his medical care expenses (hospital charges, post-operative care, doctor's fees) overseas? Explain your answer.

Answer

Question 2.5b

Should the RH subaccounts include Alia and her family's airfare to London? Explain your answer.

Answer

Question 2.5c

Should the RH subaccounts include the Al Qutub family's living expenses overseas for the duration that he is undergoing treatment? Explain your answer.

Answer

Question 2.6

Should in-effective treatments by traditional healers be included in the RH subaccounts?

Answer

Unit 2 - Answers

Question 2.1

If Nevaripine is administered to a pregnant woman to reduce the possibility of PMTCT would the expenditures be captured in RH subaccounts or HIV/AIDS subaccounts? Explain your answer.

Answer

Countries can include it in whichever subaccounts they feel programmatically encompasses HIV PMTCT services.
- but for these overlapping areas, the amount should be clearly distinguished so that it can be excluded or included for international comparisons, and care should be taken to not double count them in both the subaccounts.

Question 2.2

A breast-feeding campaign is launched, should the expenditures associated with this campaign be included in RH subaccounts or CH subaccounts?

Answer

The answer is similar to the above question. Countries can include it in whichever subaccounts they feel programmatically encompasses breast-feeding services. As long as there is no double counting of these expenditures.

Question 2.3

The added expenditures of a premature delivery that resulted from HIV/AIDS associated opportunistic infection of the mother. Should these expenditures be included in the RH subaccounts? Explain your answer.

Answer

YES. If it can be established that these expenditures are a result of the infection during pregnancy. However, this is likely to be difficult to measure as records may not document causal relationship to RH related illnesses.

Question 2.3a

Should in-kind contraceptive contributions from donors be included in RH subaccounts? If yes, how should they be captured in the RH NHA framework?

Answer

Yes. They should be included in the RH subaccounts as expenditures incurred by the donors (Rest of the World - FS 3). These in-kind contributions should be monetized by valuing them at their current market price.

Question 2.3b

When household out of payments are made in kind for a service procured at the traditional healer, would these expenditures be included in the RH subaccounts, if yes, how?

Answer

Technically, the NHA framework does accommodate in-kind transactions, however, due to the complexities in monetization of such out of pocket household transactions, they should be included only when are expected to be large and when monetization is easily possible. Remember the 2 percent rule of thumb.

Question 2.4

Donors spend and procure condoms in the year 2003. These condoms are given to the MoH that year for distribution; however, because of a backlog, they are not distributed to the facilities and subsequently not given to patients. Should the expenditures for those condoms be included in the 2003-year's NHA estimations? Please explain your answer.

Answer

NO. Because the product was never actually "consumed." The time boundary specifies an accrual method- which includes the amount obligated for "goods and services consumed and provided".

Question 2.5

Alia Al Qutub has a complicated pregnancy. Her family takes her to overseas to a referral hospital in London currently Alia's family is paying for all expenses.

Question 2.5a

Should the RH subaccounts include her medical care expenses (hospital charges, post-operative care, doctor's fees) incurred overseas? Explain your answer.

Answer

Yes, because this is a health expense. The space boundary includes health care expenditures made by a country's citizens whether in-country or abroad.

Question 2.5b

Should the RH subaccounts include Alia and her family's airfare to London? Explain your answer.

Answer

Assess the policy value of including such expenses; i.e. if the Ministry paid the airfare, then only may want to know how much of government resources is being paid for treatment abroad. In the case of the family paying for the full value of such care, it still may be important for a policy perspective; should a government or NGO consider subsidizing the costs for such RH patients' abroad, the airfare would also need to be included. When similar questions were raised at general NHA trainings- sometimes participants preferred to only include the patient's travel costs and not the family. Some other experts have stated that if such expenditures were included, they would be so large as to distort the health expenditure share.

Question 2.5c

Should the RH subaccounts include the Al Qutub family's living expenses overseas for the duration that she is undergoing treatment? Explain your answer.

Answer

No, because this not an associated health care expense and because the family would have to incur living expenses whether or not they are overseas. However, it could be argued that the difference in cost of living should be included.

Question 2.6

Should in-effective treatments by traditional healers be included in the RH subaccounts?

Answer

Yes. NHA includes all expenditures that have the primary purpose of addressing RH related illnesses, whether or not they are effective. TH expenditures are generally curative in nature (a core expenditure).

Unit 2 - Handout 1

Relevant ICD – 10 categories for RH subaccount

1. Improving antenatal, delivery and postpartum care[1]

- Chapter 15: Pregnancy, childbirth and the puerperium

O10-O16	Oedema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
O20-O29	Other maternal disorders predominantly related to pregnancy
O30-O48	Maternal care related to the fetus and amniotic cavity and possible delivery problems
O60-O75	Complications of labour and delivery
O80-O84	Delivery
O85-O92	Complications predominantly related to the puerperium
O95-O99	Other obstetric conditions, not elsewhere classified
I05-I09	Chronic rheumatic heart diseases, during pregnancy
I20-I25	Ischaemic heart diseases, during pregnancy
I30-I52	Other forms of heart disease, during pregnancy
F32	Depressive episode, during pregnancy
F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified
B58	Toxoplasmosis
B06	Rubella [German measles]
A34	Obstetrical tetanus

- Chapter 21: Factors influencing health status and contact with health services

Z32-Z39	Pregnancy: supervision, antenatal and postpartum

[1] As they pertain to the mother (due to functional boundary demarcations between RH and ChH subaccounts). For this reason the terms "perinatal" and "newborn care" have been excluded from this reference to WHO's first core aspect of reproductive health care. These services should be included in ChH subaccounts, Irrespective of the subaccount chosen, care should be taken to clearly distinguish expenditures associated with services that may be perceived to overlap with other subaccounts.

2. **Providing high-quality services for family planning, including infertility services.**

- Chapter 21: Factors influencing health status and contact with health services

Z30-Z31	Contraception and procreative management.
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
N46	Male infertility

- Chapter 14: Diseases of the genitourinary system

N97-N98	Female infertility and complications associated with artificial fertilization

3. **Eliminating unsafe abortion**

- Chapter 15: Pregnancy, childbirth and the puerperium

O00-O08	Pregnancy with abortive outcome

4. **Combating sexually transmitted infections, reproductive tract infections, cancers of the reproductive system and other gynecological morbidities**

- Chapter 1: Certain infectious and parasitic diseases

A50-A64	Infections with a predominantly sexual mode of transmission

- Chapter 2: Neoplasms

C50	Breast
C51-C58	Female genital organs
C60-C63	Male genital organs
D05-07	In situ neoplasm of breast, cervix uteri, other and unspecified genital organs
Z12.3-Z12.5	Special screening examination for neoplasm of breast, cervix, prostate

- Chapter 14: Diseases of the genitourinary system

N34	Urethritis and urethral syndrome
N39.3-N39.4	Stress incontinence, Other specified urinary incontinence
N35-N37	Urethral stricture, other disorders of urethra, urethral disorders in diseases classified elsewhere
N60-N64	Disorders of breast
N70-N77	Inflammatory diseases of female pelvic organs
N80-N98	Noninflammatory disorders of female genital tract
N99 R32	Other disorders of genitourinary tract (fistula)- Unspecified urinary incontinence

5. Sexual Health

Z70	Counseling related to sexual attitude, behaviour and orientation
Z61.4-Z61.5	Problems related to alleged sexual abuse of child

1. Other (as addendum items)

Z 41	Procedures for purposes other than remedying health state
Z41.2	Routine and ritual circumcision

sexual trafficking Classifications of the functions of Government-
(COFOG .10.9/10.4 (social protection, family and children)),
-exploitation of minors COFOG10.9/10.4

3

Unit 3

Concept of Classifications for Reproductive Health Subaccounts

Time

240 minutes

Learning Objectives

At the end of this Unit participants will:

- Comprehend the concept of the International Classification for Health Accounts (ICHA) as the basis for NHA.
- Understand the ICHA approach that allows the introduction of sub-categories within the broader ones.
    - To allow for national flexibility while maintaining international comparability
- Become familiar with approach for developing RH classifications within the NHA framework
- Become familiar with a generic list of RH classifications that retain the integrity of ICHA and the NHA framework

Content

- Slide presentations
    - Unit 3a: Concept of Classifications for RH Subaccounts
    - Unit 3b: Possible Classifications for RH, HC, HP, HF, and FS dimensions
- Exercises
- Answers

Exercises

- Exercises on Classifications

Unit 3 - Slide Presentations

Unit 3a: Concept of Classificationsfor RH Subaccounts

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Unit 3a: Concept of Classifications for Reproductive Health Subaccounts

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Forum One Communications · RTI International
Training Resources Group
Tulane University's School of Public Health

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2

Learning objectives

At the end of this Unit participants will:

- Comprehend the concept of the International Classification for Health Accounts (ICHA) as the basis for NHA.
- Understand the ICHA approach that allows the introduction of sub-categories within the broader ones.
  - To allow for national flexibility while maintaining international comparability
- Become familiar with approach for developing RH classifications within the NHA framework

3

What is the International Classification for Health Accounts (ICHA)?

- It describes the principal dimensions of health expenditures– in terms of CATEGORIES with COMMON CHARACTERISTICS
  - For example, financing sources may be divided into the following categories
    - Public funds
    - Private funds
    - Rest of the world funds

4

What is ICHA? cont'd

- Developed by OECD for System of Health Accounts (SHA)
- Each NHA table categorizes health care entities in accordance with ICHA
  - ICHA has been adapted (extended) to the developing country context for NHA- Producers' Guide
- Because it is an "internationally" accepted standard, ICHA allows for country comparisons of health expenditures

5

ICHA Approach: 4 Main health care classifications

- Begins with letter code
  - "Financing Sources" denoted by "**FS**"
  - "Financing Agents" denoted by "**HF**"
  - "Health Providers" denoted by "**HP**"
  - "Health Care Functions" denoted by "**HC**"
- Each NHA table displays the flow of funds between two of these dimensions
- Two vectors not included as "basic set of tables"
  - Resource cost denoted by "**RC**"
  - Beneficiary, presented as a multi-vectoral approach (geopolitical location, demographic characteristic, epidemiological/apparent need)

6

Health care classifications in context of RH cont'd

- **FS:** Originators of RH funds.
  - e.g. Ministry of Finance, donors, and households
- **HF:** Principal managers of RH resources- they are purchasers of services (produced by the providers)
  - Often have what is referred to as "programmatic control" over health resources distribution
  - receive funds from financing sources and use them to pay providers
  - e.g. RH Program at the Ministry of Health, Insurance schemes, and NGOs etc.

7

Health care classifications in context of RH cont'd

- HP: Entities that deliver RH care services/products
  - e.g. include private and public hospitals, pharmacies/shops, health centers
- HC: services and medical goods that are delivered for RH
  - e.g. Curative care, prevention programs
  - Core RH activities: HC
  - Health related RH activities: HCR (e.g. research)

8

Breakdown within each classification

- Within each classification, specific entities (e.g., public funds) are identified by a letter & numerical code followed by the ICHA name
  - Procedure for coding "public funds" (see SHA and PG for references)
    - Begins with letter code for the principal ICHA category; therefore, "FS" for Sources
    - Then followed by a number; therefore, "FS.1."
    - Finally, add the ICHA descriptive name for this sub-category; therefore "FS.1. Public Funds"

9

NHA Approach to Classifications

- NHA uses ICHA classifications
  - But allows the addition of "SUB-categories" to accommodate unique features of countries' health care structures
  - Respects - to the extent possible - the existing international standards
    - but is flexible enough to meet the specific policy needs required for national analysis

10

NHA approach: adding new sub-categories

- Done within the broader categories identified by ICHA.
  - e.g. an ICHA code may be: HP1.1 General Hospitals
  - if a country wants to compare spending between govt and private hospitals, it may want to add sub-classifications:
    - HP.1.1.1 Government General Hospitals
    - HP.1.1.2 Non-Government General Hospitals

11

NHA classifications' rules of thumb

- When adding new sub-categories
  - The first two numbers of the code should match ICHA categories
  - The numbers that follow are "new" and designate the nationally relevant "subcategory" classification
- Note, it is possible to eliminate ICHA categories that are not relevant to the local context.
- RH classifications fall within the overall scheme developed for general NHA.
  - e.g. the General NHA has the code
    - HC.5.1.1 prescribed medicines
    - The RH subaccounts can build upon that code
      - HC.5.1.1.1 Oral Contraceptives

12

Rules of thumb cont'd

- Each category should be designed such that it is mutually exclusive and exhaustive
  - i.e. each expenditure transaction should only fit in one-and-only-one category
- Be feasible and consistent
  - For example, if MOH is classified as
    - HF .1.1.1 in general NHA, it should be given the same code in the RH subaccounts
- Not all general NHA codes will be used for subaccounts, but the subaccount codes – at least to the 2-digit level – should be found in the general NHA framework
  - E.g. if have HC 3.1 Inpatient long term nursing care in RH subaccount,
    - Then the general NHA framework should have this code
    - with an expenditure estimate that s at a minimum the amount entered for the RH subaccount

13

Example of disease coding in context of general NHA framework

- General NHA Classifications
  - HF. 1.1.1.1 MoH
  - HF. 1.1.1.2 Other ministries (incl. MoD, Office of President, MoE
- RH Classifications
  - HF. 1.1.1.1 MoH
  - HF. 1.1.1.2 Other ministries (incl. MoD, Office of President, MoE
    - HF. 1.1.1.2.1 Ministry of Gender and social affairs
    - HF. 1.1.1.2.2 Other ministries (other than Ministry of Gender)

14

A possible RH classification breakdown- shown in unit 3b

- As presented in the RH subaccounts Guidelines
  - Based on the ICHA and NHA approach as espoused in Producers Guide (PG)
- Integrity and content of original ICHA classification is maintained
  - Particularly, two digit codes
    - e.g. HC.1.1 in general NHA is inpatient care (IP)
    - In RH subaccounts, HC.1.1 refers to only RH-related IP care
  - sub-components for RH services curative and preventive have been placed into the existing NHA framework
- This is a generic list – needs to be adapted for country specific context

15

Adapting the classifications to your context

- First determine your scope and boundaries
  - Primary purpose approach and local and international needs approach
  - Determine the type of totals you will be measuring – THE &/ NHE.
- List the possible **FS, HF, HP**, and **HC** in your country – by envisioning the types of expenditure transactions they incur
  - e.g. NGOs in country X do not generate their own funds- rather receiving them from donors.
  - Therefore, NGOs would be at **HF** and **HP** level only (and not at **FS** level)

16

Take Home Message

- RH subaccount classifications fall within the NHA framework and in accordance with ICHA
- Allows for international comparability while maintaining flexibility for the national context
- Classification can be adapted for RH but integrity and content of general NHA classification should be maintained

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Thank you

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Unit 3b:
Possible classifications for RH HC, HP, HF, and FS dimensions

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2

Learning objectives

At the end of this unit participants will:

- Become familiar with a generic list of RH classifications that retain the integrity of ICHA and the NHA framework

3

Definition of Functions in reference to RH

- RH services and medical goods
  - e.g. Curative care, prevention and public health programs, preventive commodities (oral contraceptives, condoms etc) sold as part of OP care or by private pharmacies
- "functions" are denoted by the code *HC*

4

RH Functions

NHA Code	Description
HC.1	Services of Curative Care
HC.1.1	Inpatient curative care
HC.1.1.1	Maternal health services (IP)
HC.1.1.1.1	Obstetric services for (complicated) deliveries and emergencies
HC.1.1.1.2	Ancillary services
HC.1.1.1.3	Pharmaceuticals
HC.1.1.1.4	Other
HC.1.1.2	Family planning services (IP)
HC.1.1.2.1	Sterilization
HC.1.1.2.2	Ancillary services and pharmaceuticals
HC.1.1.2.3	Abortion services
HC.1.1.2.4	Other

5

RH Functions Cont'd

NHA Code	Description
HC.1.1.3	Reproductive health services (IP, other)
HC.1.1.3.1	RTI diagnosis and treatment
HC.1.1.3.2	RH related cancers diagnosis and treatment
HC.1.1.3.3	Ancillary services
HC.1.1.3.4	Pharmaceuticals
HC.1.1.3.5	Other
HC.1.3	Outpatient curative care
HC.1.3.1	Maternal health services (OP)
HC.1.3.1.1	Antenatal care
HC.1.3.1.2	Postnatal care
HC.1.3.2	Family Planning services (OP)
HC.1.3.2.1	Family planning counseling, method application and follow-up
HC.1.3.2.2	Infertility treatment

6

RH Functions Cont'd

NHA Code	Description
HC.1.3.3	Reproductive health services (OP, Other)
HC.1.3.3.1	STI diagnosis and treatment
HC.1.3.3.2	RTI diagnosis and treatment
HC.1.3.3.3	RH related cancers diagnosis and treatment
HC.1.3.3.4	Other [ex. Ambulant treatment of gynecological morbidities]
HC.1.4	Services of curative home care
HC.1.4.1	Maternal health services [ex. Birth attendance at home, massage therapy at home]
HC.2	Services of rehabilitative care
HC.2.4.1	Maternal health services [ex. Rehab home care post emergency obstetric complications or post partum period
HC.2.4.3	Reproductive health services (Other) [ex. Rehab home care for STI, RTI, RH cancers, fistulae, and other RH related gynecological morbidities

7

RH Functions Cont'd

NHA Code	Description
HC.4	Ancillary services to medical care
HC.4.1.1	Maternal health services [ex. Pregnancy related tests, blood test, urine tests, etc]
HC.4.1.2	Family planning services [ex. Infertility tests, preparatory testing for in-vitro fertilization]
HC.4.1.3	Reproductive health services (Other) [ex. Screening for RH cancers, RTI, STI]
HC.4.2	Diagnostic imaging
HC.4.2.1	Maternal health services [ex. Diagnostic imaging – ultra sound, for pregnancy, obstetric complications and medical termination of pregnancy]
HC.4.2.3	Reproductive health services (Other) [ex. Diagnostic imaging for cancers, and other gynecological morbidities - mammography]
HC.4.3	Patient transport and emergency rescue
HC.4.3.1	Maternal health services [ex. Professional or officially arranged transportation for in-patient ambulant maternal services and rehabilitative home care - HC.1.1., HC.1.3.1, and HC .2.4.1]
HC.4.3.3	Reproductive health services (Other) [ex. Professional or officially arranged transportation for in-patient ambulant maternal services and rehabilitative home care – HC.1.1.3, HC1.3.3, and HC .2.4.3]

8

RH Functions Cont'd

NHA Code	Description
HC.5	Medical goods dispensed to outpatients
HC.5.1.1	Prescribed medicines
HC.5.1.1.1	Maternal health medicines [ex. Antibacterials,analgesia, anti-anemia]
HC.5.1.1.2	Family planning commodities [ex. Oral, hormonal]
HC.5.1.1.3	Reproductive health commodities (Other) [ex. Antibacterials,analgesia, anti-anemia]
HC.5.1.2	Over-the-counter medicines
HC.5.1.2.1	Maternal health commodities [ex. Antibacterials,analgesia, anti-anemia]
HC.5.1.2.2	Family Planning commodities [ex. Traditional oral contraceptives]
HC.5.1.2.3	Reproductive health commodities (Other) [ex. Analgesia, traditional medication]
HC.5.1.3	Other medical non-durables
HC.5.1.3.1	Maternal health commodities [ex. Safe delivery kit, dietary supplements during pregnancy – iron folic acid etc.]
HC.5.1.3.2	Family planning commodities [ex. Pregnancy test, condoms, spermacides, IUD, diaphragm]
HC.5.1.3.3	Reproductive health commodities (Other) [ex. Breast prostheses]

9

RH Functions Cont'd

NHA Code	Description
HC.6.	Prevention and public health services
HC.6.1.1	Maternal health preventive programs
HC.6.1.2	Family planning programs
HC.6.3	Prevention of communicable diseases
HC.6.3.3	Reproductive health programs (Other)
HC.6.4	Prevention of non-communicable diseases
HC.6.4.3	Reproductive health programs (Other)
HC.7	Health administration and health insurance
HC.7.1	General government administration of health
HC.7.1.1	General government administration of health (except social security)
HC.7.1.2	Administration, operation and support of social security funds
HC.7.2	Health administration and health insurance: private
HC.7.2.1	Health administration and health insurance: social insurance
HC.7.2.2	Health administration and health insurance: other private
HC. Nsk	HC expenditure not specified by kind

10

RH Functions Cont'd

NHA Code	Description
HC.R.1	Capital formation
HC.R.1.1	Infrastructure development and upgrading in the curative and preventive health care provider institutions
HC.R.1.2	Infrastructure development and upgrading in the delivery of diagnostic health care services
HC.R.1.3	Non-clinical system improvements
HC.R.2	Education and training of health personnel
HC.R.2.1	Maternal health services education/training
HC.R.2.2	Family Planning services/training
HC.R.2.3	Reproductive health services (Other) education/training
HC.R.3	Research and Development in health
HC.R.3.1	Maternal health R&D
HC.R.3.2	Family planning R&D
HC.R.3.3	Reproductive health (other) R&D

11

RH Functions Cont'd

Addendum functions	Description
AD.1	Transportation to/from medical facilities (other than professional)
AD.1.1	Transportation of client and care attendants for maternal services
AD.1.2	Transportation of client and care attendants for family planning services
AD.1.3	Transportation of client and care attendants for other sexual and reproductive health services
AD.2	Food and accommodation
AD.2.1	Food and accommodation of client and care attendants for maternal services
AD.2.2	Food and accommodation of client and care attendants for family planning services
AD.2.3	Food and accommodation of client and care attendants for other sexual and reproductive health services
AD.3	Provision of other related services
AD.3.3	Male and female circumcision
AD.4	Policy advocacy for reproductive health
AD.4.4	Policy advocacy for reproductive health
AD.5	Social and legal support
AD.5.4	Non-health IEC
AD.5.5	Empowerment of organizations

12

Definition of Provider in reference to RH

- Providers are the end users/institutions of RH funds
  - are the entities that actually DELIVER/PROVIDE the service
  - e.g. Private and public hospitals, volunteer community health workers, traditional birth attendants etc.
- Providers are denoted by the code *HP*

13

Ways of classifying providers

- Categorization based on sector
  - Public
  - Private (for profit – not-for-profit)
- Categorization based on mode of production of health care services
  - Intra-mural and extra-mural
  - Residential and ambulant
- Categorization based on position of provider in health care chain (access)
  - Primary health centres and physicians (front-line health care)
  - Referral institutions (e.g. referral hospital)
- Categorization based on target population
  - Mother and child health centres
  - Elderly health care
- Categorization based on type of intervention or function of care
  - Prevention (including promotion activities)
  - Cure
  - Rehabilitation
  - Care (e.g. nursing home, palliative care

14

Provider Classifications

NHA Code	Description
HP.1	Hospitals
HP.1.1	General Hospital
HP.1.1.1	Public Hospital
HP.1.1.2	Private Hospital
HP.2	Nursing and residential care facilities
HP.2.1	Nursing care facilities providing rehabilitative and palliative care for RH related cancer patients
HP.3	Providers of ambulatory care
HP.3.1	Offices of physicians (private clinics)
HP.3.3	Offices of other health practitioners (traditional healers)
HP. 3.4.5	All other OP multi-specialty and cooperative service centers
HP. 3.4.5.1	Antenatal clinics

15

Providers continued

NHA Code	Description
HP. 3.5	Medical and diagnostic labs
HP.3.6	Providers of home health care services
HP.3.9.3	Volunteer community health workers/animator
HP. 4	Retail sale and other providers of medical goods
HP.4.1	Dispensing chemists (shops/pharmacies/street vendors)
HP.5	Provision and administration of public health programs
HP.6	General health administration and insurance
HP.7	Other industries (rest of economy) [ex. Secondary producers, such as private households providing post delivery nursing care
HP.8	Institutions providing health related services
HP .8.1	Research institutes
HP. 8.2	Education and training institutes
HP.9	Rest of the world (all non-resident entities providing RH care to country's residents and citizens)
HP.nsk	Other

16

Definition of Financing Agent in reference to RH

- Receive funds from sources and use them to pay for/purchase RH services and goods
  - Allocates resources to providers
  - Often have 'programmatic control' and responsibility
  - manages and organizes RH funds
  - e.g. MoH national RH program, insurance companies, households, NGOs etc

    Note that sometimes entities play a dual role – MOH can be a financing agent as well as a provider
- Financing Agents are denoted by code HF

17

Financing Agents Classifications

NHA Code	Description
HF.A	*Public Sector*
HF.1.1	Territorial government
HF.1.1.1	Central government
HF.1.1.1.1	MOH RH program
HF.1.1.1.2	Other Ministries
HF.1.1.2	State/Provincial government
HF.1.1.3	Local/Municipal government
HF.1.2	Social Security Funds
HF.2.1.1	Government employee insurance programs
HF.2.5.1	Parastatal companies

18

Financing Agents Continued

NHA Code	Description
HF.B	*Nonpublic sector*
HF.2.1.2	Private sector employer insurance programs
HF.2.2	Private insurance enterprises (other than social insurance)
HF.2.3	Private households' out of pocket payment
HF.2.4	Non-profit institutions serving households (other than social insurance)
HF.2.5.2	Private nonparastatal firms and corporations (other than health insurance)
HF.3	Rest of the World

19

Definition of Financing Sources in reference to RH

- Entities that provide funds for RH health care
  - financiers of care targeted at RH
  - e.g. MoF, donors, HH
- Financing Sources are denoted by code FS

20

Financing Sources Classifications

NHA Code	Description
FS.1	Public Funds
FS.1.1	Territorial government funds
FS.1.1.1	Central government revenue
FS.1.1.2	Regional and municipal government revenue
FS.1.2	Other public funds
FS.1.2.1	Return on assets held by public entity
FS.1.2.2	Other

21

Financing Sources contd.

NHA Code	Description
FS.2	Private Funds
FS.2.1	Employer Funds
FS.2.2	Household Funds
FS.2.3	Non profit institutions serving individuals
FS.2.4	Other private funds
FS.2.4.1	Return on assets held by a private entity
FS.2.4.2	Other
FS.3	Rest of the world funds

22

Take home message

- Be consistent with ICHA and the NHA approach
  - Retain the first two numbers of ICHA categories- before creating subcategories
- When in doubt – consult the OECD SHA manual or the PG

23

Application questions

Exercise 1: Sort the following entities as Financing sources, Agents, Functions, and Providers – see the attached handout

Exercise 2: Assign ICHA code to each of the entities you just classified (from the handout)

Exercise 3: What are the main health care entities in your country and how would you sort them into FS, HF, HP and HC?

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Thank you

Reports related to this presentation are available at www.healthsystems2020.org and www.africahealth2010.aed.org

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Unit 3 - Exercises

Exercise 1

Sort the entities below into Financing Sources, Financing Agents, Providers, and Functions

Answer

Entities	Classification
Administration of NIP	
National Airline	
Allstar Private Insurance Inc.	
Ambulance transport	
Ultrasound equipment	
Central government hospital	
Chrisjay Medical University Hospital	
HIV/AIDS and other STI prevention and education program for young girls	
Hjortsberg International Development Agency (HIDA)	
Households	
Surgery for Fistula	
Chemotherapy for cervical cancer (outpatient)	
Sex education for high school students that includes FP counseling	
Ministry of Finance	
Ministry of Health	
Ministry of Education	

Entities	Classification
National Insurance Program (NIP)	
Private clinics	
Private firms – e.g. Coca-Cola	
Blood smear done in a hospital-	
Private pharmacies	
Public pharmacies	
Salaries of MoH personnel	
The service of Intermittent preventive therapy for pregnant women –	
NFPP (National Family Plan. Prog.) Clinics	
National Petroleum Company	
Tien Women's Health Clinic (NGO)	
Traditional healer	

Exercise 2

Assign the ICHA codes to the above entities.

Answer

Exercise 3

What are the main health care entities in your country and how would you sort them into Financing Sources, Financing Agents, Providers, and Functions?

Answer

Unit 3 - Answers

Exercise 1

Sort the entities below into Financing Sources, Financing Agents, Providers, and Functions

Answer

Entities	Classification
Administration of NIP	(Function HC.7.2.1 – Health Adm. and Health Insurance; Social Insurance)
National Airline	(Most often Financing Agent HF.2.5.1 – State owned enterprises depending on how autonomous the org. is it can be placed under either public or private sector classification. Occasionally it can be classified as Financing Sources FS1.3)
Allstar Private Insurance Inc.	(Financing Agent – HF.2.2 Private insurance enterprises (other than social insurance)
Ambulance transport	(Function HC.4.3 – Patient transport and emergency rescue)
Ultrasound equipment	(Function HCR.1 – Capital formation for health care provider institutions)
Central government hospital	(Provider HP.1.1.1 Public general hospitals)
Chrisjay Medical University Hospital	(HP.1.2 – University general hospitals)
HIV/AIDS and other STI prevention and education program for young girls	(It depends – if this program is captured under the HIV/AIDS program, then it would be not included in this subanalysis. If it is a part of the RH program then - Function HC. 6 Prevention and Public Health Services)
Hjortsberg International Development Agency (HIDA)	(FS3 Rest of the world)
Households	(Financing Sources FS2.2 Household funds and Financing Agents HF.2.3 Private household out of pocket payments)
Surgery for Fistula	(Function HC.1.1 Inpatient curative care)
Chemotherapy for cervical cancer (outpatient)	(HC 1.3, and HP 1.1)
Sex education for high school students that includes FP counseling	(could be either HC 6.1 or HC 6.2)
Ministry of Finance	(Financing Sources FS.1.1) Central govt. revenue
Ministry of Health	(Financing Agent HF.1.1.1.1 Central govt. revenue – MOH)
Ministry of Education	(Financing Agent HF.1.1.1.2 Central govt. revenue – MOE)

Entities	Classification
National Insurance Program (NIP)	(Financing Agent HF.1.2.1) Within social security funds – public social insurance
Private clinics	(Provider – HP.3.1.1 Office of private physicians)
Private firms – e.g. Coca-Cola	(Financing Sources FS.2.1 Private employer funds)
Blood smear done in a hospital-	HC.1.3
Private pharmacies	(Provider HP.4.1.1 Private dispensing chemists)
Public pharmacies	(Provider HP.4.1.2 Public dispensing chemists)
Salaries of MoH personnel	(Function HC.7.1.1 General govt. administration of health)
The service of Intermittent preventive therapy for pregnant women –	since it is "personal" care- part of HC.1.3 OP care and not HC.6...
NFPP (National Family Plan. Prog.) Clinics	(Provider HP 3.4.1 Family Planning Centers)
National Petroleum Company	(Most often Financing Agent HF.2.5.1 – State owned enterprises depending on how autonomous the org. is it can be placed under either public or private sector classification. Occasionally it can be classified as Financing Sources FS.1.3)
Tien Women's Health Clinic (NGO)	(Provider HP.3.4.9 – All other outpatient community and other integrated care centers
Traditional healer	(Provider HP 3.3.2 – Offices of other health practitioners – Traditional healers)

Exercise 2

Assign the ICHA codes to the above entities.

Exercise 3

What are the main health care entities in your country and how would you sort them into Financing Sources, Financing Agents, Providers, and Functions?

Answer

Input from the participants

Unit 3 - Handout

ICHA RH Function Classification

Code	Description
HC.1	Services of curative care
HC.1.1	Inpatient curative care
HC.1.1.1	Maternal health services (IP)
HC.1.1.1.1	Obstetric services for (complicated) deliveries and emergencies
HC.1.1.1.2	Ancillary services
HC.1.1.1.3	Pharmaceuticals
HC.1.1.1.4	Other
HC.1.1.2	Family planning services (IP) [ex. Sterilization, abortion, vasectomy
HC.1.1.2.1	Sterilizations
HC.1.1.2.2	Ancillary services and pharmaceuticals
HC.1.1.2.3	Abortion services
HC.1.1.2.4	Other
HC.1.1.3	Reproductive health services (IP, other)
HC.1.1.3.1	RTI diagnosis and treatment
HC.1.1.3.2	RH related cancers diagnosis and treatment
HC.1.1.3.3	Ancillary services
HC.1.1.3.4	Pharmaceuticals
HC.1.1.3.5	Other
HC.1.3	Outpatient curative care
HC.1.3.1	Maternal health services (OP)
HC.1.3.1.1	Antenatal care
HC.1.3.1.2	Postnatal care
HC.1.3.2	Family Planning services (OP)
HC.1.3.2.1	Family planning counseling, method application and follow-up
HC.1.3.2.2	Infertility treatment
HC.1.3.3	Reproductive health services (OP, Other)
HC.1.3.3.1	STI diagnosis and treatment
HC.1.3.3.2	RTI diagnosis and treatment
HC.1.3.3.3	RH related cancers diagnosis and treatment
HC.1.3.3.4	Other [ex. Ambulant treatment of gynecological morbidities]
HC. 1.4	Services of curative home care
HC.1.4.1	Maternal health services [ex. Birth attendance at home, massage therapy at home]
HC.2	Services of rehabilitative care
HC.2.4.1	Maternal health services [ex. Rehab home care post emergency obstetric complications or post partum period
HC.2.4.3	Reproductive health services (Other) [ex. Rehab home care for STI, RTI, RH cancers, fistulae, and other RH related gynecological morbidities
HC.4	Ancillary services to medical care
HC.4.1.1	Maternal health services [ex. Pregnancy related tests, blood test, urine tests, etc]
HC.4.1.2	Family planning services [ex. Infertility tests, preparatory testing for in-vitro fertilization]
HC.4.1.3	Reproductive health services (Other) [ex. Screening for RH cancers, RTI, STI]

Code	Description
HC.4.2	Diagnostic imaging
HC.4.2.1	Maternal health services [ex. Diagnostic imaging – ultra sound, for pregnancy, obstetric complications and medical termination of pregnancy]
HC.4.2.3	Reproductive health services (Other) [ex. Diagnostic imaging for cancers, and other gynecological morbidities - mammography]
HC.4.3	Patient transport and emergency rescue
HC.4.3.1	Maternal health services [ex. Professional or officially arranged transportation for in-patient ambulant maternal services and rehabilitative home care - HC.1.1., HC.1.3.1, and HC .2.4.1]
HC.4.3.2	Reproductive health services (Other) [ex. Professional or officially arranged transportation for in-patient ambulant maternal services and rehabilitative home care – HC.1.1.3, HC1.3.3, and HC .2.4.3]
HC.5	Medical goods dispensed to outpatients
HC.5.1.1	Prescribed medicines
HC.5.1.1.1	Maternal health medicines [ex. Antibacterials,analgesia, anti-anemia]
HC.5.1.1.2	Family planning commodities [ex. Oral, hormonal]
HC.5.1.1.3	Reproductive health commodities (Other) [ex. Antibacterials,analgesia, anti-anemia]
HC.5.1.2	Over-the-counter medicines
HC.5.1.2.1	Maternal health commodities [ex. Antibacterials,analgesia, anti-anemia]
HC.5.1.2.2	Family Planning commodities [ex. Traditional oral contraceptives]
HC.5.1.2.3	Reproductive health commodities (Other) [ex. Analgasia, traditional medication]
HC.5.1.3	Other medical non-durables
HC.5.1.3.1	Maternal health commodities [ex. Safe delivery kit, dietary supplements during pregnancy – iron folic acid etc.]
HC.5.1.3.2	Family planning commodities [ex. Pregnancy test, condoms, spermacides, IUD, diaphragm]
HC.5.1.3.3	Reproductive health commodities (Other) [ex. Breast prostheses]
HC.6.	Prevention and public health services
HC.6.1.1	Maternal health preventive programs
HC.6.1.2	Family planning programs
HC.6.3	Prevention of communicable diseases
HC.6.3.3	Reproductive health programs (Other)
HC.6.4	Prevention of non-communicable diseases
HC.6.4.3	Reproductive health programs (Other)
HC.7	Health administration and health insurance
HC.7.1	General government administration of health
HC.7.1.1	General government administration of health (except social security)
HC.7.1.2	Administration, operation and support of social security funds
HC.7.2	Health administration and health insurance: private
HC.7.2.1	Health administration and health insurance: social insurance
HC.7.2.2	Health administration and health insurance: other private
HC. nsk	HC expenditure not specified by kind

Code	Description
HC.R	Health care-related function
HC.R.1	Capital formation
HC.R.1.1	Infrastructure development and upgrading in the curative and preventive health care provider institutions
HC.R.1.2	Infrastructure development and upgrading in the delivery of diagnostic health care services
HC.R.1.3	Non-clinical system improvements
HC.R.2	Education and training of health personnel
HC.R.2.1	Maternal health services education/training
HC.R.2.2	Family Planning services/training
HC.R.2.3	Reproductive health services (Other) education/training
HC.R.3	Research and Development in health
HC.R.3.1	Maternal health R&D
HC.R.3.2	Family planning R&D
HC.R.3.3	Reproductive health (other) R&D

Addendum Functions	Description
AD.1	Transportation to/from medical facilities (other than professional)
AD.1.1	Transportation of client and care attendants for maternal services
AD.1.2	Transportation of client and care attendants for family planning services
AD.1.3	Transportation of client and care attendants for other sexual and reproductive health services
AD.2	Food and accommodation
AD.2.1	Food and accommodation of client and care attendants for maternal services
AD.2.2	Food and accommodation of client and care attendants for family planning services
AD.2.3	Food and accommodation of client and care attendants for other sexual and reproductive health services
AD.3	Provision of other related services
AD.3.3	Male and female circumcision
AD.4	Policy advocacy for reproductive health
AD.4.4	Policy advocacy for reproductive health
AD.5	Social and legal support
AD.5.4	Non-health IEC
AD.5.5	Empowerment of organizations

ICHA RH Provider Classification

Code	Description
HP.1	Hospitals
HP.1.1	General Hospital
HP.1.1.1	Public Hospital
HP.1.1.2	Private Hospital
HP.2	Nursing and residential care facilities
HP.2.1	Nursing care facilities providing rehabilitative and palliative care for RH related cancer patients
HP.3	Providers of ambulatory care
HP.3.1	Offices of physicians (private clinics)
HP.3.3	Offices of other health practitioners (traditional healers)
HP. 3.4.5	All other OP multi-specialty and cooperative service centers
HP.3.4.5.1	Antenatal clinics
HP. 3.5	Medical and diagnostic labs
HP.3.6	Providers of home health care services
HP.3.9.3	Volunteer community health workers/animator
HP. 4	Retail sale and other providers of medical goods
HP.4.1	Dispensing chemists (shops/pharmacies/street vendors)
HP.5	Provision and administration of public health programs
HP.6	General health administration and insurance
HP.7	Other industries (rest of the economy) [ex. Secondary producers, such as private households providing post delivery nursing care]
HP.8	Institutions providing health related services
HP.8.1	Research institutes
HP.8.2	Education and training institutes
HP.9	Rest of the world (all non-resident entities providing RH care to country's residents and citizens)
HP.nsk	Other

ICHA RH Financing Agent Classifications

Code	Description
HF.A	*Public Sector*
HF.1.1	Territorial government
HF.1.1.1	Central government
HF.1.1.1.1	MOH RH program
HF.1.1.1.2	Other Ministries
HF.1.1.2	State/Provincial government
HF 1.1.3	Local/Municipal government
HF 1.2	Social Security Funds
HF.2.1.1	Government employee insurance programs
HF.2.5.1	Parastatal companies
HF.B	Nonpublic sector
HF.2.1.2	Private sector employer insurance programs
HF.2.2	Private insurance enterprises (other than social insurance)
HF.2.3	Private households' out of pocket payment
HF.2.4	Non-profit institutions serving households (other than social insurance)
HF.2.5.2	Private nonparastatal firms and corporations (other than health insurance)
HF.3	Rest of the World

ICHA RH Financing Source Classifications

Code	Description
FS.1	Public Funds
FS.1.1	Territorial government funds
FS.1.1.1	Central government revenue
FS.1.1.2	Regional and municipal government revenue
FS.1.2	Other public funds
FS.1.2.1	Return on assets held by public entity
FS 1.2.2	Other
FS.2	Private Funds
FS.2.1	Employer Funds
FS.2.2	Household Funds
FS.2.3	Non profit institutions serving individuals
FS2.4	Other private funds
FS.2.4.1	Return on assets held by a private entity
FS. 2.4.2	Other
FS. 3	Rest of the world funds

4

Unit 4

Setting-up and Reading the RH Tables

Time

60 minutes

Learning Objectives

At the end of this Unit participants will:

- Understand the structure of each table
- Be able to label the headings of rows and columns based on ICHA for each table
- Understand how each of the totals are calculated
  - THE and NHE

Content

- Slide presentation
- Discussion question
- Handouts

Exercises

- Discussion question

Unit 4 - Slide Presentation

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Unit 4:
Setting-up and Reading the RH Tables

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2

Learning Objectives

At the end of this unit participants will:

- Understand the structure of each table
- Be able to label the headings of rows and columns based on ICHA for each table
- Understand how each of the totals are calculated
  - THE and NHE

3

NHA Tables That Should Be Done at a Minimum

- Same basic 4 tables for RH subaccounts, as in the general NHA
  - Table 1. FS x HF
    - Tells you:
      - how much is contributed by financiers?
      - Who manages RH resources and where do they get their funds from
  - Table 2. HF x HP
    - Tells you:
      - how financing agents allocate funds across different providers
  - Table 3. HF x HC
    - Tells you: the ultimate use of funds given by financing agents
  - Table 4. HP x HC
    - Tells you: how providers spend their RH resources

4

Reading a NHA Table

- Within a matrix:
- Funds flow downward from the

  "originators" (column headings)

  ↓

  "recipients/users" (row headings)
- The total amount spent by each "originator" is shown at the bottom of each column
- The total amount received by each "recipient/user" is included at the end of each row

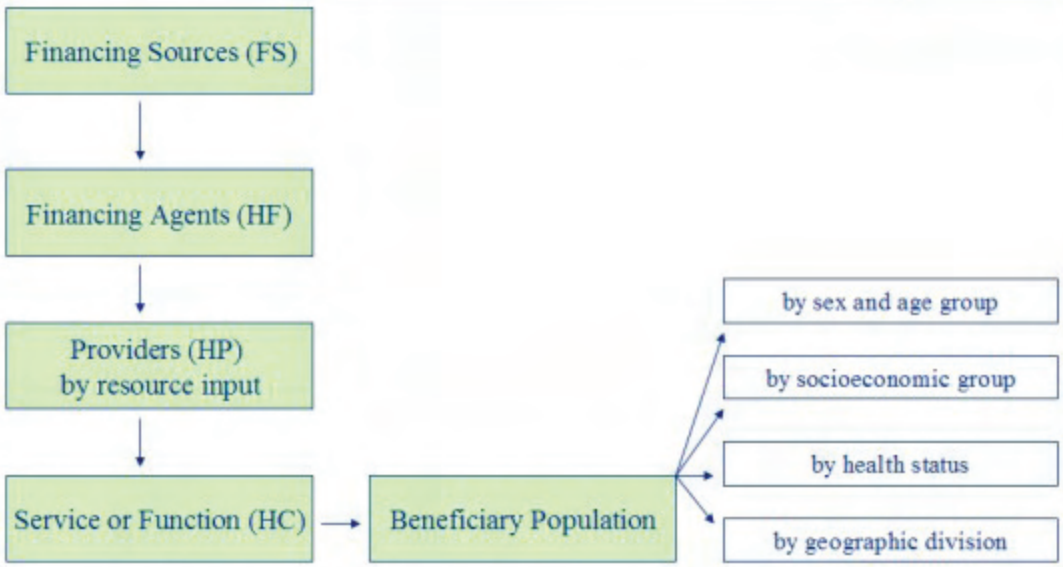
5

Understanding Flows Between Tables

- ROW Headings of One Matrix become COLUMN headings or "originators" of the next table
- Therefore, ROW totals of First Matrix becomes COLUMN "totals" of the second table
- Total Health Expenditure (THE) - the number contained in the cell at the bottom right corner of each table- is the same in every table

6

Relationship between Actors



7

Understanding Flows Between Tables

1)	Primary Sources				
Financing Agents	S.1.1 Central Gov. (MoF)	S.3. Rest of the World (Donors)	S.2.1 Employer Funds	S.2.2 Household Funds	**TOTALS**
HF.1.1.1.1 Ministry of Health	A	B			**A +B**
HF.1.1.1.2 Ministry of Education	C				**C**
HF.2.2 Private Insurance Enterprises			D	E	**D +E**
HF. 2.3 Private households' out-of-pocket payment				F*	**F***
TOTALS					**G**

2)	Financing Agents				
Providers	HF.1.1.1.1 MoH	HF.1.1.1.2 MoE	HF.2.2 Private Insurance Enterprises	HF.2.3 Households	**TOTALS**
HP.1.1.1 Public General Hospitals	W		X		
HP.1.1.2 Private General Hospitals		C			
HP.3.4.5.1 Public Outpatient Clinics			Y		
TOTALS	**W =A+B**	**C**	**X+Y= D+E**	**F**	**G**
* direct transfer of payment					

8

Possible RH specific tables

- Can do the four basic tables: RH expenditures
  - by financing source and financing agent (FSxHF)
  - by financing agent and provider (HFxHP)
  - by provider and function (HPxHC)
  - by financing agent and function (HFxHC)
- Optional tables showing the distribution of reproductive health spending among the population and inputs: RH expenditures
  - for beneficiaries by age and sex of beneficiaries
  - for beneficiaries by socio-economic status of beneficiaries
  - for beneficiaries by health status of beneficiaries
  - for beneficiaries by geographic region
  - Costs of resources used to produce reproductive health services and goods

9

Possible RH specific tables – contd.

- Additional recommended Table not found in the NHA Producer Guide
  - RH expenditures by financing source and function (FSxHC)

10

Possible "Total" Health Expenditure Estimates

- For purposes of international comparison:
  - Total Current Expenditure on Health (TCHE) = HC.1-7 only
    - Includes spending for personal health care (HC1-5), collective health services and for the operation of the system's financing agents (HC6-7)
  - Total Expenditure on Health (THE) = HC.1-7 and HCR.1
    - This is what is usually measured by most countries.
- For national purposes:
  - National Health Expenditure (NHE) = THE + HCR.2-5*
    - It may or may not include any of the health related functions from HCR.2-5.
    - Draws upon national policy perspectives of what is considered health care

11

Targeted and Untargeted Expenditures

- RH subaccounts can provide a set of the 4 tables
  - that just show targeted spending
  - and/or another set that show both targeted and untargeted spending for RH services and or products
- Targeted or earmarked funds
  - those for which the primary purposes are explicitly declared as treatment and prevention of RH related diseases
  - e.g. by donors, NGOs, HH, government
- Non-targeted expenditures
  - incurred at non-market providers (where care is subsidized)
  - intermediate costs in service production - e.g. portion of staff salaries etc. that will go towards supporting RH
    - Note that at for-profit providers, the intermediate costs are embedded in the price charged to the patient/ insurance

12

Financing Sources to Financing Agents

		Financing Source (FS)							
		FS.1 Public Funds	FS.2 Private Funds				FS.3	FS.nsk	
Code	Financing Agent (HF)	FS.1.1.1 Central Gov Revenue	FS.2.1.1 Parastatal Employer Funds	FS.2.1.2 Private Employer Funds	FS.2.2 Households	FS.2.3 NPISH (Local implementing agencies)	Cooperating Partners (Rest of the World)	Not specified by any kind	Row Total
HF.1.1.1.1	MoH (MiniSante)								
HF.1.1.2	DISGAS + Health districts								
HF.1.1.1.2	Other Ministries								
HF.1.3	FARG								
HF.1.2	Social Security Fund (CSR-Caisse Sociale")								
HF.2.1.	Public Employer insurance program - RAMA (Rwanda medical insurance)								
HF.2.5.1	Parastatals								
HF.2.2	Private Insurance Enterprises (other than social insurance)- Mutuelles, COGEAR, SONARWA etc								
HF.2.3	Private household out of pocket payments								
HF.2.4	NPISH (implementing agencies)								
HF.2.5	Private firms and corporations (other than health insurance)								
HF.3	Rest of World								
HF.nsk	Not specified by any kind								
	Column Total (THE1)								
HF.4	Financing Agents spending on Health Related Items								
	Column Total (NHE1)								

13

Financing Agents x Providers

		Financing Agent													
		HF.A Public Sector							HF.B Private Sector				HF.3 RoW	HF.nsk	
		HF.1.1.1.1	HF.1.1.2	HF.1.1.2.2	HF.1.3	HF.1.2	HF.2.1	HF.2.5.1	HF.2.2	HF.2.3	HF.2.4	HF.2.5	HF.3	HF.nsk	
	Provider	MoH (MinSante)	DGSAS + Health districts	Other Ministries	FARG	Social Security Fund (CSR-Caisse Sociale*)	Public Employer insurance program - RAMA (Rwanda medical insurance)	Parastatals	Private Insurance Enterprises (other than social insurance)- Mutuelles, COGEAR,	Private household out of pocket payments	NPISH (implementing agencies)	Private firms and corporations (other than health insurance)	Rest of World	Not specified by any kind	Row Total
HF.1.1.1	Public Hospitals														
HF.1.1.2.1	Gov't assisted not-for-profit hospitals														
HF.1.1.2.2	Private hospital for-profit														
HF.1.2	Mental health & substance abuse hospitals														
HF.2.1	Offices of physicians (private clinics)*														
HF.2.3	Offices of other health practitioners (traditional healers)														
HF.2.4.5.1	Public health centers														
HF.2.4.5.2	Government assisted not-for-profit health														
HF.2.5	Medical and diagnostic laboratories														
HF.2.9.2	Blood banks (CNTS transfusion)														
HF.4.1	Dispensing chemists														
HF.5	Provision and admin of public health programs														
HF.6	General health administration and insurance														
HF.6.1	Government administration of health														
HF.6.3	Other social insurance administration (RAMA, FARG, mutuelles)														
HF.6.9	Other administration														
HF.nsk	Providers not specified by any kind														
	Column Total THE1														
	HF Totals From FS x HF Table														
HF.8	Providers of Health Related Services														
HF.8.1	Research Institutions														
HF.8.2	Education and training institutions														
	Subtotal for health related														
	Column Total: NHE1														

14

Financing Agents x Functions

		Financing Agent													
		HF.A Public Sector							HF.B Private Sector				HF.3 RoW	HF.nsk	
		HF.1.1.1.1	HF.1.1.2	HF.1.1.2	HF.1.3	HF.1.2	HF.2.1	HF.2.5.1	HF.2.2	HF.2.3	HF.2.4	HF.2.5	HF.3	HF.nsk	
	Function	MoH (MinSante)	DGSAS + Health districts	Other Ministries	FARG	Social Security Fund (CSR-Caisse Sociale*)	Public Employer insurance program - RAMA (Rwanda medical insurance)	Parastatals	Private Insurance Enterprises (other than social insurance)- Mutuelles, COGEAR, SONARWA etc	Private household out of pocket payments	NPISH (implementing agencies)	Private firms and corporations (other than health insurance)	Rest of World	Not specified by any kind	Row Total
HC.1.1	In-patient curative care														
HC.1.3	Out-patient curative care														
HC.5.1.1+HC5.1.2	Pharmaceuticals														
HC.5.1.3+ HC5.2	Other medical non durables and durables														
HC.6	Prevention and administration of public health programmes														
HC.6.1	Maternal and child care, family planning and														
HC.6.3	Prevention of communicable disease (e.g.,														
HC6.4	Prevention of noncommunicable diseases														
HC.6.6	Training within public health programs														
HC.6.9	All other miscellaneous public health services														
HC.7	Health administration and insurance														
HC.7.1.1	General gov't administration of health (except social security)														
HC.7.1.2	Admin, operation and support of social security funds (CSR, RAMA)														
HC.7.3	Other administration														
HCR.1	Capital formation for health care provider institutions														
HC.nsk	Not specified by kind														
	Column Total THE1														
HCR.2	Education & Training														
HCR.3	Research & Development														
	Sub total column														
	Column Total NHE1														

15

Providers to Functions

		Provider														
		HF1.1.1	HF1.1.2.1	HF1.1.2.2	HF1.2.1	HF2.3	HF2.4.5.1	HF2.5	HF2.6.2	HF4.1	HF5	HF6	HF.nas		HF8	
	Function	Public Hospitals	Govt associated not-for-profit hospitals	Private hospitals for-profit	Offices of physicians (private clinics)*	Offices of other health practitioners (traditional healers)	Public health centers	Medical and diagnostic laboratories	Blood banks (CNTS transfusion)	Dispensing chemists	Provision and admin of public health programs	General health administration and insurance	Providers not specified by any kind	THE Row Total	Providers of Health Related Services	NHE Row Total
HC.1.1	In patient curative care															
HC.1.2	Out patient curative care															
HC.1.1.1 +HC5.1.2	Pharmaceuticals															
HC.1.1.2 +HC5.1.2	Other medical non durables and durables															
HC.6	Prevention and administration of public health programmes															
HC.6.1	Maternal and child care, family planning and counseling															
HC.6.3	Prevention of communicable disease (e.g., HIV/AIDS, malaria)															
HC6.4	Prevention of noncommunicable diseases															
HC.6.6	Training within public health programs															
HC.6.8	All other miscellaneous public health services															
HC.7	Health administration and insurance															
HC.7.1.1	General govt administration of health (except social security)															
HC.7.1.2	Admin, operation and support of social security funds (CSSF, RAMA)															
HC.7.3	Other administration															
HCR.1	Capital formation for health care provider institutions															
HC.nas	Not specified by kind															
	Column Total THE1															
HCR.2	Education & Training															
HCR.3	Research & Development															
	Column Total NHE1															

16

Take Home Message

- There are 4 minimum tables
  - Table 1. FS x HF
  - Table 2. HF x HP
  - Table 3. HF x HC
  - Table 4. HP x HC
- What tables are computed depends on the policy environment and data availability

17

Discussion Question

- Coca-Cola distributes Condoms through its own clinic
  - Which cell (e.g. FS.1xHF.2) would this expenditure amount be included in the
    - FSxHF table?
    - HFxHP table?
    - HFxHC table?
    - HPxHC table?

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Thank you

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HEALTH SYSTEMS 2020

Unit 4 - Exercises

Discussion question

Coca-cola distributes ITNs through its own clinic.

Which cell (e.g. FS.1xHF.2) would this expenditure amount be included in the

- FSxHF table?
- HFxHP table?
- HFxHC table?
- HPxHC table?

Answer

Unit 4 - Answers

Discussion question

Coca-cola distributes ITNs through its own clinic.

Which cell (e.g. FS.1xHF.2) would this expenditure amount be included in the

- FSxHF table?
- HFxHP table?
- HFxHC table?
- HPxHC table?

Answer

FS 2.1 x HF 2.5

HF 2.5 x HP 3.1

HF 2.5 x HC 1.3.1

Example of Financing Sources X Financing Agents (FS X HF) Reproductive Health Subaccounts Table

TARGETED and NONTARGETED FUNDS

		Financing Source (FS)							
				FS.2 Private Funds				FS.3	
Code	Financing Agent (HF)	FS.1.1.1 Central Gov Revenue FS.1.1.1.4 could not be disaggregated	FS. 1.2 Other Public funds	FS.2.1.1 Parastatal Employers	FS.2.1.2 Private Employers	FS.2.2 Households	FS.2.4 Other private funds	Rest of the World (Donors)	Row Total
HF.1.1.1.1	MoH (MiniSante)	381,018,157	7,319,331					1,266,978,717	1,655,316,206
HF.1.1.1.2	Other Ministries	381,683,130						3,954,674	385,637,804
HF.1.2	Social Security Fund (CSR)			933,678	555,926				1,489,604
HF.1.3	FARG	202,656,747				3,252,496			205,909,243
HF.2.1.1	Gvt Employees Insurance Programme (RAMA)	40,881,780		258,485,395		14,212,861	43,916,792		357,496,828
HF.2.1.2	Private Employees Insurance Programme				11,892,637	1,011,934			12,904,570
HF.2.1.3	Mutuelles (Private & Community based)	45,027,074		62,180,234	625,964	380,567,629		431,793,492	920,194,393
HF. 2.5.1	Parastatal companies			142,909,466					142,909,466
HF.2.2	Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)*			986,510	9,839,008	2,032,588			12,858,106
HF.2.3.	Private household out of pocket payments					988,390,962			988,390,962
HF.2.4	Non profit institutions (NGOs, SWAA, PROFEMME)	1,697,920				630,664		3,787,420,572	3,789,749,155
HF.2.5.2	Private Non Parastatal Firms				54,140,906				54,140,906
HF.3	Rest of World							2,034,328,716	2,034,328,716
	Column Total (THE)	1,052,964,808	7,319,331	465,495,284	77,054,441	1,390,099,133	43,916,792	7,524,476,170	**10,561,325,959**
HF. Health relat	Financing Agents spending on Health Related Items							171,590,514	171,590,514
	Column Total (NHE)	1,052,964,808	7,319,331	465,495,284	77,054,441	1,390,099,133	43,916,792	7,696,066,685	**10,732,916,474**
Addendum	Financing Agents spending on NONHEALTH								0
	Column Total: RHE (health, health related and nonhealth)	1,052,964,808	7,319,331	465,495,284	77,054,441	1,390,099,133	43,916,792	7,696,066,685	**10,732,916,474**

Example of Financing Agents X Providers (HF X HP) Reproductive Health Subaccounts Table

TARGETED and NONTARGETED FUNDS

		Financing Agent													
		HF.A Public Sector								HF B: Non Public Sector				HF.3 ROW	
		HF.1.1.1.1	HF.1.1.1.2	HF.1.2	HF.1.3	HF.2.1.1	HF.2.1.2	HF.2.1.3	HF. 2.5.1	HF.2.2	HF.2.3.	HF.2.4	HF.2.5.2	HF.3	
	Provider	MoH (MiniSante)	Other Ministries	Social Security Fund (CSR)	FARG	Gvt Employees Insurance Programme (RAMA)	Private Employees Insurance Programme	Mutuelles (Private & Community based)	Parastatal companies	Private Insurance Enterprises (other than social insurance: COGEAR, SONARWA, etc)	Private household out of pocket payments	Non profit institutions (NGOs, SWAA, PROFEMME)	Private Non Parastatal Firms	Rest of World	Row Total
HP.1.1.1.1	National Referral Gvt Hospital	684,916,022	327,535,778		123,013,220			125,493,450			303,597,085	928,456,771		1,742,779,746	4,235,792,072
HP.1.1.1.2	National Referral Private Hospital	421,160,081		614,287	34,184,910	101,109,933	3,668,046			3,654,839	79,656,074				644,048,171
HP.1.1.2.1	District Gvt: Hospitals	15,893,350	17,414,624	223,234	12,422,928	25,500,297	677,040	202,674,756		674,602	107,781,802	157,148,996	26,561		540,438,190
HP.1.1.2.2	District Agrees Hospitals	6,878,939	11,189,741	181,476	10,099,094	3,854,109	478,768	164,762,387		477,044	46,649,979	421,371,951	22,992		665,966,481
HP.3.1	Office of physicians (private clinics)*	6,982,331									191,954,634				198,936,965
HP.3.3.1	Community health workers	2,302,366				204,483,235	4,110,703		142,909,466	4,095,902		69,985,930	54,091,353		481,978,956
HP.3.3.3	Other health practitioners										3,170,884				3,170,884
HP.3.4.5.1	Public health centers	180,804,456	15,279,253	247,800	13,790,007	12,563,948	2,397,117	224,978,056		2,388,486	39,344,208	312,893,816			804,687,148
HP.3.4.5.2	Government assisted not-for-profit health centers (Agrees)	111,297,661	13,738,118	222,806	12,399,084	9,985,306	1,572,896	202,285,745		1,567,232	35,741,758	266,549,161			655,359,766
HP.3.4.5.3	NGO health centers	20,904,568									38,620,612	597,791,165			657,316,345
HP.4.1	Dispensing chemists	22,527,922									141,873,925	226,054,768			390,456,615
HP.5	Providers + admin of public health programs	176,506,718	480,290									809,496,598		291,548,970	1,278,032,575
HP.6	General health administration and insurance	5,141,792													5,141,792
	Column Total THE	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,789,749,155	54,140,906	2,034,328,716	10,561,325,959
	HF Totals From FS x HF Table	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,789,749,155	54,140,906	2,034,328,716	10,561,325,959
HP.8.2	Education and training institutions											171,590,514			171,590,514
	Subtotal for health related	-	-	-	-	-	-	-	-	-	-	171,590,514	-	-	171,590,514
	Column Total: NHE	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,961,339,669	54,140,906	2,034,328,716	10,732,916,474
	Providers of NONHEALTH RH programs														-
	Subtotal for nonhealth	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Column Total: RHE (health, health related and nonhealth)	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,961,339,669	54,140,906	2,034,328,716	10,732,916,474

Example of Financing Agents X Health Care Function (HF x HC) Reproductive Health Subaccounts Table

TARGETED and NONTARGETED FUNDS

	Financing Agent	HF.A Public Sector								-				HF.3 ROW	
		HF.1.1.1.1	HF.1.1.1.2	HF.1.2	HF.1.3	HF.2.1.1	HF.2.1.2	HF.2.1.3	HF. 2.5.1	HF.2.2	HF.2.3.	HF.2.4	HF.2.5.2	HF.3	-
	Function	MoH (MiniSante)	Other Ministries	Social Security Fund (CSR)	FARG	Gvt Employees Insurance Programme (RAMA)	Private Employees Insurance Programme	Mutuelles (Private & Community based)	Parastatal companies	Private Insurance Enterprises (other than social insurance: COGEAR, SONARWA, etc)	Private household out of pocket payments	Non profit institutions (NGOs, SWAA, PROFEMME)	Private Non Parastatal Firms	Rest of World	Row Total
HC. 1.1.	IP curative care (deliveries)	983,617,620	355,816,760	1,087,464	181,825,413	123,501,754	7,754,587	587,520,205	-	7,726,665	112,919,822	1,265,045,861	49,554	1,718,626,082	5,345,491,787
HC.1.3.11	Antenatal care	74,981,832	29,340,754	402,140	24,083,830	233,995,074	5,149,984	332,674,188	142,909,466	5,131,440	620,492,914	636,333,330	54,091,353	24,153,664	2,183,739,969
HC1.3.13.1	FP consultation and issuance of ORAL CONTRACEPTIVES	139,293,169	-	-	-	-	-	-	-	-	3,459,800	8,208,313	-	-	150,961,282
HC.1.3.13.2	FP consultation and issuance of CONDOMS	3,173,669	-	-	-	-	-	-	-	-	61,832	426,440	-	-	3,661,941
HC.1.3.13.4	FP consultation and issuance of IMPLANTS	61,405,352	-	-	-	-	-	-	-	-	17,617,600	102,343,908	-	-	181,366,859
HC.1.3.13.5	FP consultation and issuance of INJECTABLES	188,668,132	-	-	-	-	-	-	-	-	91,965,070	486,812,504	-	-	767,445,705
HC.1.3.13.7	FP consultations not disaggregated	-	-	-	-	-	-	-	-	-	-	185,041,504	-	-	185,041,504
HC.5.1.1.1	ORAL CONTRACEPTIVES purchased at private pharmacy/shop	12,663,015	-	-	-	-	-	-	-	-	16,840,000	8,755,068	-	-	38,258,083
HC.5.1.1.3	INJECATBLES purchased at private pharmacy/shop	3,914,277	-	-	-	-	-	-	-	-	-	-	-	-	3,914,277
HC.5.1.3.1	CONDOMS purchased at private pharmacy/shop	5,950,630	-	-	-	-	-	-	-	-	125,033,925	217,299,700	-	-	348,284,255
HC.6.1.1.1	Antentatal care programs	-	-	-	-	-	-	-	-	-	-	42,828,792	-	-	42,828,792
HC.6.1.1.2	Programs related to safe delivery	-	-	-	-	-	-	-	-	-	-	64,967,157	-	-	64,967,157
HC.6.1.1.4	Other Maternal health programs	-	-	-	-	-	-	-	-	-	-	3,132,000	-	-	3,132,000
HC.6.1.1.2.6	OTHER FP programs	-	-	-	-	-	-	-	-	-	-	540,055,990	-	-	540,055,990
HC.6.1.1.2.7	FP programs that could not be disaggregated	-	-	-	-	-	-	-	-	-	-	158,512,659	-	-	158,512,659
HC.6.1.3	Adolescent reproductive health	-	185,113	-	-	-	-	-	-	-	-	-	-	-	185,113
HC.6.1.5	Other RH programs	-	295,177	-	-	-	-	-	-	-	-	-	-	-	295,177
HC.6.1.6	RH programs that could not be disagggregated	181,648,510	-	-	-	-	-	-	-	-	-	-	-	291,548,970	473,197,479
HCR.1	Capital formation for health care provider institutions	-	-	-	-	-	-	-	-	-	-	69,985,930	-	-	69,985,930
	Column Total THE	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,789,749,155	54,140,906	2,034,328,716	**10,561,325,959**
HCR.2	Education & Training	-	-	-	-	-	-	-	-	-	-	171,590,514	-	-	171,590,514
	Sub total column	-	-	-	-	-	-	-	-	-	-	171,590,514	-	-	*171,590,514*
	Column Total NHE	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,961,339,669	54,140,906	2,034,328,716	**10,732,916,474**
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
AD.5	Prevention and treatment of victims of sexual violence	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AD.6	Gender non-health programs (Women's empowerment, equity)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
	sub total column	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Column Total- RH health, health related, nonhealth	1,655,316,206	385,637,804	1,489,604	205,909,243	357,496,828	12,904,570	920,194,393	142,909,466	12,858,106	988,390,962	3,961,339,669	54,140,906	2,034,328,716	10,732,916,474

Example of Providers X Health Care Function (HP x HC) Reproductive Health Subaccounts Table

TARGETED and NONTARGETED FUNDS (Continued)

		Provider															
		HP.1.1.1.1	HP.1.1.1.2	HP.1.1.2.1	HP.1.1.2.2	HP.3.1	HP.3.3.1	HP.3.3.3	HP.3.4.5.1	HP.3.4.5.2	HP.3.4.5.3	HP.4.1	HP.5	HP.6		HP.8.2		
	Function	National Referral Gvt Hospital	National Referral Private Hospital	District Gvt Hospitals	District Agrees Hospitals	Office of physicians (private clinics)*	Community health workers	Other health practitioners	Public health centers	Government assisted not-for-profit health centers (Agrees)	NGO health centers	Dispensing chemists	Providers + admin of public health programs	General health administration and insurance	THE Row Total	Education and training institutions	NHE Row Total	Providers of NONHEALTH RH programs
HC. 1.1.	IP curative care (deliveries)	3,645,298,714	575,665,939	155,699,379	147,356,849	43,719,159	-	3,170,884	381,326,552	393,254,311	-	-	-	-	5,345,491,787			
HC.1.3.11	Antenatal care	461,784,938	54,417,239	338,386,231	506,240,535	141,267,300	409,690,659	-	160,029,259	99,799,480	12,124,327	-	-	-	2,183,739,969			
HC1.3.13.1	FP consultation and issuance of ORAL CONTRACEPTIVES	7,630,433	1,866,888	2,708,925	1,172,474	1,586,662	2,302,366	-	71,604,989	44,664,516	17,424,029	-	-	-	150,961,282			
HC.1.3.13.2	FP consultation and issuance of CONDOMS	262,952	107,225	93,352	40,405	289,484	-	-	1,206,179	777,364	884,981	-	-	-	3,661,941			
HC.1.3.13.4	FP consultation and issuance of IMPLANTS	27,699,573	5,993,273	9,833,790	4,256,248	5,093,662	-	-	8,470,657	5,459,213	114,560,443	-	-	-	181,366,859			
HC.1.3.13.5	FP consultation and issuance of INJECTABLES	16,664,545	5,997,608	5,916,179	2,560,633	6,980,699	-	-	135,715,624	81,287,853	512,322,565	-	-	-	767,445,705			
HC.1.3.13.7	FP consultations not disaggregated.	76,450,916	-	27,800,333	4,339,338	-	-	-	46,333,889	30,117,028	-	-	-	-	185,041,504			
HC.5.1.1.1	ORAL CONTRACEPTIVES purchased at private pharmacy/shop	-	-	-	-	-	-	-	-	-	-	38,258,083	-	-	38,258,083			
HC.5.1.1.3	INJECATBLES purchased at private pharmacy/shop	-	-	-	-	-	-	-	-	-	-	3,914,277	-	-	3,914,277			
HC.5.1.3.1	CONDOMS purchased at private pharmacy/shop	-	-	-	-	-	-	-	-	-	-	348,284,255	-	-	348,284,255			
HC.6.1.1.1	Antentatal care programs	-	-	-	-	-	-	-	-	-	-	-	42,828,792	-	42,828,792			
HC.6.1.1.2	Programs related to safe delivery	-	-	-	-	-	-	-	-	-	-	-	64,967,157	-	64,967,157			
HC.6.1.1.4	Other Maternal health programs	-	-	-	-	-	-	-	-	-	-	-	3,132,000	-	3,132,000			
HC.6.1.1.2.6	OTHER FP programs	-	-	-	-	-	-	-	-	-	-	-	540,055,990	-	540,055,990			
HC.6.1.1.2.7	FP programs that could not be disaggregated	-	-	-	-	-	-	-	-	-	-	-	158,512,659	-	158,512,659			
HC.6.1.3	Adolescent reproductive health	-	-	-	-	-	-	-	-	-	-	-	185,113	-	185,113			
HC.6.1.5	Other RH programs	-	-	-	-	-	-	-	-	-	-	-	295,177	-	295,177			
HC.6.1.6	RH programs that could not be disaggregated	-	-	-	-	-	-	-	-	-	-	-	468,055,687	5,141,792	473,197,479			
HCR.1	Capital formation for health care provider institutions	-	-	-	-	-	69,985,930	-	-	-	-	-	-	-	69,985,930			
	Column Total-THE	4,235,792,072	644,048,171	540,438,190	665,966,481	198,936,965	481,978,956	3,170,884	804,687,148	655,359,766	657,316,345	390,456,615	1,278,032,575	5,141,792	10,561,325,959			
HCR.2	Education & Training															171,590,514	171,590,514	
	Column Total-NHE															171,590,514	10,732,916,474	
-	-																	-
AD.5	Prevention and treatment of victims of sexual violence																	-
AD.6	Gender non-health programs (Women's empowerment, equity)																	-
-	-																	-
	Column Total- RH health, health related, nonhealth																	10,732,916,474

5

Unit 5
Data Collection Approach

Time

180 minutes

Learning Objectives

At the end of this Unit participants will:

- Understand what data is required and why it is required
- Be able to list possible data sources
    - Health information systems
    - Secondary data
    - Ongoing surveys
    - Primary Data collection
- Comprehend the need for a detailed data collection plan

Content

- Slide presentation
- Exercises
- Answers
- Handouts

Exercises

- Discussion questions

Unit 5 - Slide Presentation

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Unit 5:
Data Collection Approach

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2

Learning objectives

At the end of this unit participants will:

- Understand what data are required and why
- Be able to list possible data sources
  - Health information Systems
  - Secondary Data
  - Ongoing surveys
  - Primary Data collection
- Comprehend the need for a detailed data collection plan

3

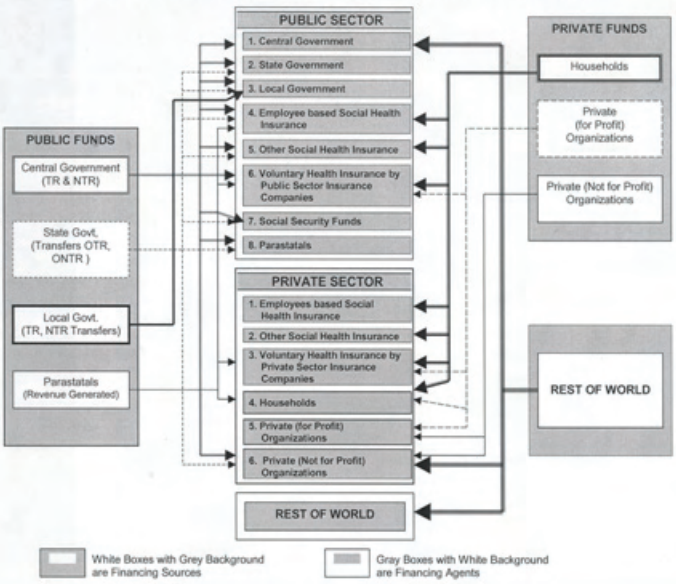
Draw a spider web of funds flow

- To determine where you can begin the search for data
  - Map the presumed flow of funds for RH from
    - Financing Sources to
    - Financing Agents to
    - Providers to
    - Functions
- Start with financing agents (as these are most closely associated with allocation of RH funds)

4

Spider-web of funding flows: Karnataka state, India

Figure 5.1 : Flow of Funds to the RH System from Financing Sources to Financing Agents



5

Approach to data collection

- Requires data from numerous sources
  - Make a census of all data sources
  - Wherever possible have two sources of information for each cell in the NHA matrices
    - Triangulation
- Dependent on
  - Availability of existing data
  - Financial budget for surveys (if need be)
  - Level of cooperation by gatekeepers of data sources
  - NHA team stability and motivation
  - Ability of team to keep up data collection momentum
    - through regular follow-up visits/calls with respondents and key informants.

6

The type of data needed

- Expenditure Information
  - on general NHA
  - on RH health services and goods
- When expenditure data are not available
  - Obtain unit cost estimates (as detailed as possible) and utilization data
- Additional data for the computation of policy indicators and weighting to national level. e.g:
  - GDP
  - population
  - Medical inflation
  - Total number of donors in the country that give to RH

7

NHA questions informed by data from the following entities

RH Health Care Entities	NHA-related questions addressed by data from respective entity
Donors	1. What financing agents do donors (as FS) contribute to? How much? (FSxHF table) 2. Do donors transfer their funds directly (as financing agents) to providers? If so, to which ones, how much and for what functions? (HFxHP, HPxHC, and HFxHC tables)
NGOs	1. Where do NGOs (as financing agents) receive their RH funds? From what financing sources? And how much is received? (for the FSxHF table) 2. Do NGOs serve as financing sources by generating their own revenue from local philanthropy (e.g. church groups)? If so, how much is generated by this mechanism? (for the FSxHF table) 3. How do NGOs allocate their funds across each type of provider and function? (for the HFxHP, HPxHC, and HFxHC tables)

8

NHA questions informed by data from the following entities cont'd

RH Health Care Entities	NHA-related questions addressed by data from respective entity
Relevant Government entities (e.g. MoF, MoH, MoA)	1.How much and to whom does the Ministry of Finance (financing source) give RH funds? (for theFSxHF table) 2. Where do the various ministries (excluding the Ministry of Finance) (as financing agents) receive their RH funds? From what financing sources? And how much is received? (for the FSxHF table) 3. How do the various ministries (excluding the Ministry of Finance) allocate their RH funds across each type of provider and function? (for the HFxHP, HPxHC and HFxHC tables)
Providers* (e.g. hospitals clinics pharmacies, traditional healers etc)	1. Which financing agents (the principal managers of RH funds) contribute to providers? How much is received from each financing agent? (for the HFxHP tables) 2. How do providers spend their funds across each type of function? (for the HPxHC table)

9

NHA questions informed by data from the following entities cont'd

RH Health Care Entities	NHA-related questions addressed by data from respective entity
Households	1. How much do households pay out-of-pocket (as financing agents) for inpatient and outpatient services at various providers? (FSxHF, HFxHP, HFxHC, and HPxHC tables)
Insurance Company/ Schemes*	1. Where do Insurance companies (as financing agents) receive their funds for RH coverage? From what financing sources? And how much is received? (FSxHF table) 2. How do insurance companies allocate their RH funds across each type of provider and function? (HFxHP, HFxHC, and HPxHC tables)
Employers*	1. How much and to whom (financing agents such as insurance schemes) do employers (financing sources) give funds ultimately used for RH services and goods? (FSxHF table) 2. How much goes towards on-site health services for employees? And for what types of services? (FSxHF, HFxHP, HFxHC, and HPxHC tables)

10

Identifying data sources

- Examine potential sources from the following categories in the order listed
  - Existing information systems
  - Secondary data
  - Ongoing surveys- to which rider questions can be added
  - Developing RH subaccount-specific surveys

11

Identifying data sources cont'd

- Consult with the "spider web"
- Consider:
  - Agencies to whom transactors routinely submit financial reports
    - e.g. budget office, audit office, licensing office etc.
  - Agencies that collect data on transactors through routine surveys
    - e.g. survey of hospitals

12

Assessment of data source

- For each source identified, evaluate the
  - Year of estimation
    - Does it coincide with the NHA year of estimation?
  - Scope of information provided
    - Does it look at all RH expenditures or perhaps just some?
    - Does it offer national level data or regional?
  - Quality and reliability of the data
    - How was this information collected- what was the response rate?
  - Level of detail
    - Can it provide functional level detail?

13

1. Health Information Systems

- Depending on country, can provide a wealth of information
  - Utilization information
  - Diagnosis data- can help with functional classifications
- In countries where RH is a priority for the government, there may be specific RH indicators that are tracked
- Also, by reviewing a country's Health Information System (HIS)
  - can identify its data gaps or areas that can be improved on if subaccount was institutionalized

14

Example of RH-related indicators in Rwanda's HIS

Indicators Tracked:
Hospital Level
Number of new consultations due to a) abortion, b) sterilization, c) menstrual troubles, d) male genital problems, e) inflammation of the pelvis, f) other gyno-obstetric conditions. Can be broken down by age.
Number of hospitalization cases due to a) normal deliveries, b) puerperal infections, c) post-partum complications, d) vesico-vaginal fistulas, e) premature delivery. Can be broken down by age
Number of deliveries with complications: a) needing cesarians, b) vacuum extraction, c) ruptured uterus, d) maternal mortality, e) other
Number of consultations (new and recurring) for family planning methods (IUD, vasectomies, implants, oral contraceptives, injectables etc).
Total Expenditures in past month for a) gyno-obstetric hospitalizations, b) deliveries,
Health Centre Level
Number of OP and IP cases for a) gyno-obstetric reasons, b) urethral collapse", c) male and female genital ulcers. Can be broken down by age.
Number of normal and complicated deliveries at health center
Number of deliveries assisted outside a health center
Number of prenatal consultations (and when they occurred- in the first trimester, second trimester etc)
Number of FP products user: for pill, injectables, implants, IUD etc
Number of participants and seminars held for family planning, antenatal care, postnatal care.
Total Expenditures in past month for a) delivery, b) prenatal consultations, c) antenatal care and postnatal

15

2. Secondary data

- Studies/reports already in existence
  - National sources
    - e.g. in Rwanda- Ministry of Health and CAMERWA (Directorate of pharmacies) annual expenditure reports
    - International Sources, such as NEWVERN, DHS, CMS etc
    - RH Interchange at *www.rhsupplies.org* and then click on RHINTERCHANGE

16

2. Secondary Data

Government Records

Data Sources	Strengths	Weaknesses
Budget Expenditures (executed budgets) Import and Export Records on drugs (e.g. RH Commodities) National Accounts data / pharmaceutical industry records – for retail sale information.	Most accessible type of data Reliable and accurate Comprehensive in coverage of relevant activity Available on regular basis Consistent reporting rules	May be distorted to misrepresent/ protect/ advance a program May be disaggregated in a manner that differs from NHA categories Discrepancies between audited and un-audited records Tend to have a time lag (b/c of bureaucratic process of auditing)

17

2. Secondary Data cont'd

Donor and NGO Records (international agencies)

Data Sources	Strengths	Weaknesses
■Routine donor and NGO surveys (e.g donor mapping studies) ■Donor reports of fund transfer to MoH	■ Routine annual surveys of all donor assistance ■ Provides country background and health sector info (e.g., WB Health Sector Report) ■ Lists key players in health sector	■ Sometimes too generic ■ Difficult to monetize in-kind donations ■ When donors make donations directly to a NGO or a local entity, the financing data are likely to be missed ■ Difference in disbursements between donors and ministries

18

3. Ongoing Surveys

- Add rider questions to
  - Ongoing general NHA surveys (e.g. for donors, NGOs, Insurance, employers, providers)
  - Ongoing HH surveys
    - DHS
      - Conducted every 5 years
      - Include some questions on RH expenditures.
    - Multiple Indicator Cluster Survey (UNICEF)
      - to monitor the health situation of children. Include modules RH expenditure.
  - Other ongoing surveys developed through National accounting offices

19

3. Ongoing Surveys- considerations

- When deciding to add questions ask
  - What is the sample size of the ongoing survey? Will it be useful for obtaining NATIONAL and ANNUAL estimates?
  - How many questions need to be added to determine who spends, how much , and for what services?
    - Goal is to add as few questions as possible
  - What is the time period that respondents will be reporting within?
  - What is the workplan time line for the ongoing survey? Does it coincide with your deadlines for producing subaccount estimates?

20

4. Developing separate survey(s)

- Before resorting to developing a separate survey
  - Consider if data for an entity can be obtained from another entity
    - e.g. Expenditures by a private-for-profit clinic may be obtained from the household data survey
      - because the price charged to patients incorporates intermediate costs
  - Assess your financial budget to determine the sample size that can be afforded if a survey were to be conducted
  - Consider the time implications of implementing a separate survey
    - There are many steps entailed in conducting a survey and each needs to be well coordinated

21

4. Developing separate survey(s)

- Steps entailed in survey implementation
  1. Design the questionnaire,
  2. Pre-test the instrument,
  3. Determine the sampling frame,
  4. Administer the questionnaires and ensure that they are properly filled in —

     if this stage is not carefully monitored, response rates may be quite low and will draw-out the data collection process
  5. Enter data into software program
  6. Clean data set
  7. Data analysis (weighting to national level)

22

Household data considerations

- Most important for RH Subaccounts as expenditures are usually substantial
- Difficult to estimate through sources other than surveys
  - Because substantial OOP spending may occur at facilities that do not regularly provide/ record OOP revenue
    - e.g. private sector shops, traditional healers, mobile street vendors
    - in these cases, cannot obtain data from providers
- Alternatively, a small sample of shops and drug peddlers could be surveyed
  - but the difficulty will arise in determining how to weigh the sample to the national level

23

Problems with household surveys

- NHA team should be cognizant of 3 types of problems:
  - Sampling error: when sample framework is not representative of overall population
  - Non-sampling error: associated with defects in the design and implementation of the survey
  - Lack of annual repetition of most household surveys: lack of availability of data over time

Source: WHO 2007

24

Creating a Data Collection Plan

- Outlines the action plan for collecting primary and
- Secondary data and clearly answers the following:
- Who is ultimately responsible for collecting each type of data?
- What types of information is needed? What is the level of detail? What time period should the data cover?
- When will the data be collected? What is the deadline for obtaining the data?
- Where should the team get the data?
  - **Ask the steering committee to:**
    - **Identify secondary data sources**
    - **Facilitate access to the data**

25

Creating a Data Plan cont'd

Why?

- To ensure timeliness of the activity
- Division of labor among team members makes the process easier to manage
- Easier to identify any breakdown in the data collection process when it is divided into small chunks

26

Example of a Data Plan for Secondary Sources

Kenya NHA Data Plan			
For Secondary Sources	*RECORD-KEEPER: Nzoya Dhim*		
Name of data source	**NHA Team Member Responsible for Getting Data**	**Person to contact (eg. From Steering Committee) to Obtain Information**	**Deadline to Collect Data Source and Report Back to Team**
Government Records:			
MoHExecuted budgets or Expenditure Returns 2001-2002 June-July (for all levels such as provincial, district,etc)	Mosira M Martin (responsible)- Finance Department, MoH; Henry G Onyiego (assisting)- Department of Planning, MoH	No need to contact 3rd party	1-Oct-02
Expenditure returns (2001-2002)Other Ministries (incl. MoE, MoD, MoLocal Government, MoHome Affairs)	Mosira M Martin (responsible)- Finance Department, MoH; Henry G Onyiego (assisting)- Department of Planning, MoH	Need to contact each Ministry PS; Steven Muchiri- Department of Planning, MoH will facilitate making the contacts	15-Nov-02

27

Example of a Data Plan for Primary Sources

Kenya NHA Data Plan					
For Primary Sources	*RECORD-KEEPER: Geoffery Kimani, Department of Planning, MoH*				
Name of data source	**NHA Team Member Responsible for Coordinating Survey Instrument Design and Development of**	**Person to Contact (eg. From Steering Committee) to consult when designing the survey**	**Deadline to meet with contact person and finalize survey instrument**	**Deadline to Pre-test**	**Deadline to Implement Survey and Collect Data**
Insurance Company Survey	Nzoya Dhim, Department of Planning, Ministry of	Commissioner of Insurance	30-Nov-02	15-Jan-03	15-Feb-03
Household Survey	Professor Nganda, University of Nairobi	David Nalo, CBS Director	15-Oct-02	30-Nov-03	February 15 -March 15, 2003

28

Take home message

- NHA requires information from a lot of sources
- Data collection is the pivotal step in the NHA implementation process
  - Should begin by taking a census of available data.
- Identify data sources in the following order:
  - Existing information systems
  - Secondary data
  - Ongoing surveys- to which rider questions can be added
  - Developing RH subaccount-specific surveys
- The more primary data required the greater the cost and time to complete the subaccount

Application questions

- For tonight's homework, country teams should complete the following tasks in their exercise books:
  - **Draw the 'spider web' of RH funds in your country**
  - **List potential data sources according to the following:**
    - **What kind of data can be identified from existing information systems?**
    - **What relevant secondary data are available?**
    - **Are there any ongoing surveys- to which rider questions can be added? If so, please specify?**
    - **Would your country need to develop any RH subaccount-specific surveys? If so, for what entities?**
    - **Are there any entities that you foresee will be difficult to collect data on? Specify**
- Tomorrow, two groups will be RANDOMLY selected to report back to the class in the form of a 10 minute presentation

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Thank you

Reports related to this presentation are available at www.healthsystems2020.org and www.africahealth2010.aed.org

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HEALTH SYSTEMS 2020

Unit 5 - Application Exercises

Question 5.1

In the space below, draw the 'spider web' of RH funds in your country.

Question 5.2

What kind of data can be identified from existing information systems?

Question 5.3

What relevant secondary data are available?

Question 5.4

Are there any ongoing surveys- to which rider questions can be added? If so, please specify?

Question 5.5

Would your country need to develop any reproductive health subaccount-specific surveys? If so for what entities?

Question 5.6

Are there any entities that you foresee will be difficult to collect data on? Please specify.

Unit 5 - Answers

Question 5.1

In the space below, draw the 'spider web' of RH funds in your country.

Question 5.2

What kind of data can be identified from existing information systems?

Answer

Question 5.3

What relevant secondary data are available?

Answer

Question 5.4

Are there any ongoing surveys- to which rider questions can be added? If so, please specify?

Answer

Question 5.5

Would your country need to develop any reproductive health subaccount-specific surveys? If so for what entities?

Answer

Question 5.6

Are there any entities that you foresee will be difficult to collect data on? Please specify.

Answer

Unit 5 - Handout

Indicators tracked by Mexico

Expenditure distribution by financing agent and comparison by year [Distribución del gasto entre agentes financieros, y el comparativo de cómo ha variado este gasto para 2003,2004 y próximamente 2005.]
Public expenditure on health per female beneficiary by state among non insured population [Gasto público por mujer beneficiaria por estado para población sin acceso a la seguridad social.]
Public expenditure on health per female beneficiary by state among insured population [Gasto público por mujer beneficiaria por estado para población con acceso a la seguridad social.]
Expenditure distribution on reproductive and gender health functions [Distribución del gasto en SR y EG por funciones]
Expenditure distribution on reproductive and gender health functions by financing agents [Distribución del gasto en SR y EG por funciones por agente financiero.]
Expenditure on reproductive curative care by financing agents [Participación de los agentes en el financiamiento en el gasto de la atención curativa en SR.]
Expenditure distribution on reproductive ambulatory health care by financing agents [Participación de los agentes en el financiamiento del gasto de la curativa ambulatoria en SR y EG por agente financiero.]
Expenditure distribution on medicines by financing agents [Participación de los agentes en el financiamiento del gasto en medicamentos.]
Expenditure distribution on prevention and public health by financing agents [Participación de los agentes en el financiamiento del gasto en prevención y salud pública para SR.]
Expenditure distribution on reproductive health by provider [Participación de los proveedores en el financiamiento del gasto en SR.]
Expenditure distribution on reproductive functions by programme [Gasto en SR por programa y funciones relevantes en cada programa.]
Expenditure distribution on reproductive health functions by programme by financing agent [Gasto en SR por programa y funciones relevantes para cada agente financiador.]
Expenditure per female beneficiary on reproductive health functions by state by financing agent [Gasto en SR por beneficiaria por estado para cada agente financiador.]
OOPS by reproductive health function [Gasto de los hogares por funciones de SR.]
Share of private spending by programme [Distribución porcentual del gasto privado por programa.]
Public spending per female beneficiary of perinatal and maternal health programme by martenal mortality rate and perinatal mortality rate [Gasto público por beneficiaria en Salud materna perinatal y su asociación con Tasas de Mortalidad Materna y Mortalidad perinatal]
Public spending per female beneficiary of family planning programme by state -infant mortality rate and fertility rate [Gasto público por beneficiaria en Planificación familiar por estado y su asociación con tasas de fecundidad y mortalidad infantil por estado.]
Public spending per female beneficiary of early detection of cervical cancer programme by state as share of state-mortality rate by cervical cancer [Gasto público por beneficiaria en CACU por estado y su asociación con tasas de mortalidad por CaCU por estado.]
Public spending per female beneficiary of breast cancer programme by state as share of state-mortality rate by breast cancer [Gasto público por beneficiaria en Cáncer de mama por estado y su asociación con tasas de mortalidad por cáncer de mama.]

6

Unit 6
Data Analysis Approach

Time

420 minutes

Learning Objectives

At the end of this unit participants will:

- Be familiar with the types of data needed for the analysis phase
- Understand the basic tasks inherent in analysis
- Become aware of the guiding principles and tips when populating NHA matrices
- Be familiar with and know how to address
  - Boundary-related issues
  - Between other subanaccounts
  - Between health and health-related
  - Commodity-related issues
- Be familiar with approaches for estimating non-targeted spending
- Apply the principles and strategies discussed in Unit 6a and Unit 6b
- Gain practical experience in
  - Analyzing a primary dataset
  - Filling in the NHA matrices
  - Determining non-targeted spending
  - Addressing data conflicts and data gaps

Content

- Data analysis issues and approaches
- Avoiding double counting
- Resolving data conflicts
- Order of filling in the tables

Exercise

- Solving the case study

Unit 6 - Slide Presentation

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Unit 6a:
Data Analysis Approach

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2

Learning objectives

At the end of this unit participants will:

- Understand what data are required and why
- Be able to list possible data sources
  - Health information Systems
  - Secondary Data
  - Ongoing surveys
  - Primary Data collection
- Comprehend the need for a detailed data collection plan

3

Purpose of data analysis

- Populate at a minimum 4 NHA matrices (for a given year) on RH expenditures
  - FSxHF
  - HFxHP
  - HFxHC
  - HPxHC
- Compute critical policy indicators for the NHA report and for stakeholders
- Generate some rough conclusions regarding the RH Subaccounts- do the findings make sense?

4

Getting organized: What data are needed?

Purpose of needed information	Examples of the types of data needed
Populate NHA matrices	• Clean data sets from NHA surveys • Secondary data (as listed in the NHA data plan)
Weigh primary datasets to national level	Surveys may target only a sample of the 'universe' for a given entity. To extract national estimates from such datasets, appropriate weights must be applied. May require additional information e.g — • Total number of donors & NGOs and their relative size that contribute to health and RH

Convert currencies	• Official exchange rate from
	  ■ local currency to US $ for year of estimation (take average of the year)
	  ■ donor reported currencies to local currency
	• Conversion rate to estimate purchasing power of parity

5

Getting organized: What data are needed? *Cont'd*

Purpose of needed information	Examples of the types of data needed
Adjust those datasets with earlier/later timeframes to NHA year of estimation	▪ Inflation rates; medical or general (also needed for time series comparisons). ▪ Population growth rate
To compute key policy indicators e.g. gov. health expenditure/ total gov. expenditure	▪ GDP ▪ Total population (for expenditure per capita estimates) ▪ Total population of women of child bearing age (15-49 years) ▪ Total government expenditure ▪ Total donor expenditure

6

Getting organized: What data are needed? *Cont'd*

Purpose of needed information	Examples of the types of data needed
Inform estimation techniques particularly when disaggregated expenditure data is not available.	▪ Utilization data: e.g. % of IP admissions attributed to RH, -These proportions may be used to estimate the amount of general revenues (not targeted) that is indirectly used for RH ▪ General expenditure breakdown at facilities between IP and OP -The same ratio may be used to disaggregate expenditure at a given facility if functional data are not available. ▪ Health commodity or service unit costs
Verify expenditure estimates	▪ Existing cost and utilization studies ▪ Cost recovery data ▪ Other studies on national or subnational health expenditures (e.g. Public expenditure reviews etc).

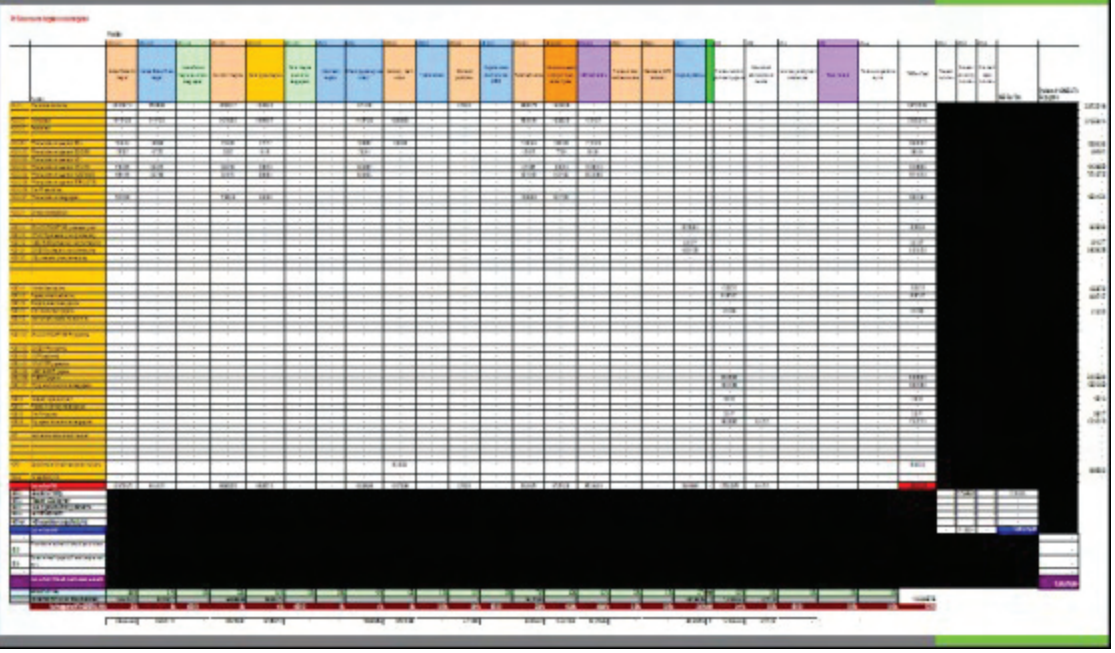
7

What else is needed to get started?

- Template for the NHA tables
  - Should incorporate
    - Classifications in row and column headings
    - Formulae for summation of columns and rows
    - Links between tables for cross-checking purposes
    - Links to a "policy indicator" sheet
    - If conducted concurrently with general NHA, link subaccount table to general NHA tables
- The same template, with minor revisions, can be used the following year

8

Template sample



9

Steps entailed in data analysis

1. Tally national annual amounts received and SPENT by each entity (t-accounts/data summary)
   - Map each transaction to NHA classifications.
   - For survey datasets
     1. weigh to national level and
     2. If needed, annualize to year of estimation.
   - Estimate non-targeted spending
   - DOCUMENT, DOCUMENT, DOCUMENT every approach and assumption taken!
2. Populate the matrices
   - Link each cell to the T-account file
   - Involves:
     1. Resolving data conflicts
     2. Addressing data gaps
     3. Choosing best data sources

10

Recommended order to computing T-accounts/data summaries

- Start with those entities (generally FINANCING AGENTS) that have a lot of expenditure detail regarding RH:
  - In sub-Saharan Africa, good to start with the following:
    1. NGOs
    2. Government- Ministry of Health (central and subnational level), followed by other ministries
    3. Donors
    4. HH
    5. Providers
    6. Employers, Insurance etc.

11

Creating 'T-accounts'/data summaries for each entity

- See Producers' Guide
  - Two columns: revenues and expenditures
  - Guiding principle- both columns must equal
    - Essentially, only capture revenue that was ultimately spent and used in the year of estimation
  - Each transaction should be mapped to NHA classification
    - Table below: illustrative T-account for MoH acting as HF

Expenditure	Revenue	NHA classification	
		At FS level	At HC level
40 US$ Contraceptives	50 US$. from donors	FS.3 (50US$)	HC.1.3.3 (40 US$)
30 US$ IEC	30 US$. from MoF	FS.1.1.1 (30 US$.)	HC.6.3.5 (30 US$)
10 US$ M&E			HC.6.3.7 (10 US$)
80 US$ total	80 US$. total		

12

Recommended order to filling in the matrices

- HFxHPxHC Combination table
  - Automatically generates HFxHP, HPxHC
  - May need to use general expenditure breakdown ratios for the dimension that you do not have actual data one (e.g. provider or function)
    - i.e. through the health information system, it is known that in public hospitals, 70% is spent on IP care and 30% on OP care
    - If you know that an NGO gives 100US$ to public hospitals for nothing specifically and have no further information, then assume that 70 US$ went to IP and 30 US$ went to OP
- HFxHC
- FSxHF

13

Illustrative HFxHPxHC combination table

Provider and Function		Financing Agent							
		HF.1.1.1.1 Ministry of Health	HF.1.1.1.3 Ministry of Defense	HF.1.1.2 Regional Gov	HF.1.2 NIA	HF.2.1.1 Government group insurance	HF.2.3 Households	Total	Check against FA x P
HP.1.1.1.1	MOH general hospitals								
	HC.1.1 Inpatient Curative								
	HC.1.3 Outpatient Curative								
	HC.R.1 Capital Formation								
HP.1.1.1.2	MOD hospitals								
	HC1.1 Inpatient Curative								
	HC1.3 Outpatient Curative								
	HC4 Ancillary Services								
	HCR.1 Capital Formation								
HP.1.1.1.3	Regional general hospitals								
	HC.1.1								
	HC.1.3								
	Total FA spending								
	Check against FAxP								

14

Populating the matrices

- No two data sources will report the same amount
  - Therefore, need to select one or compute an alternate estimate
  - Some questions to consider:
    - Is one data source more reliable than the other?
      - Perhaps one survey had a higher response rate?
    - Do both data sources measure the same data and conform to the same boundaries?
      - e.g., one entity's definition of health expenditures may include spending on sanitation services whereas other data sources may exclude such spending
    - Do both data sources measure the same time period?
    - How was the data measured- cash vs accrual?

15

Populating the matrices; Some tips

- Avoid double counting
  - Data can be obtained from originator and recipient of the fund transfer
    - you will obtain different estimates for the same transaction
  - When both data sources are used in NHA tables, there is a possibility of duplication
    - e.g. HH may generally report entire OOP spending inclusive of what has been reimbursed by employers
      - Therefore, avoid counting this amount under both employers and HH

16

Populating the matrices; Some tips *cont'd*

- The 2% rule; rule of thumb
  - if an expenditure transaction is likely to be less than 2% of THE for RH and
  - if you do not have data for this cell and
  - if it is not of significant policy interest
  - … then leave cell blank and move on
    - Time vs quality trade-off

17

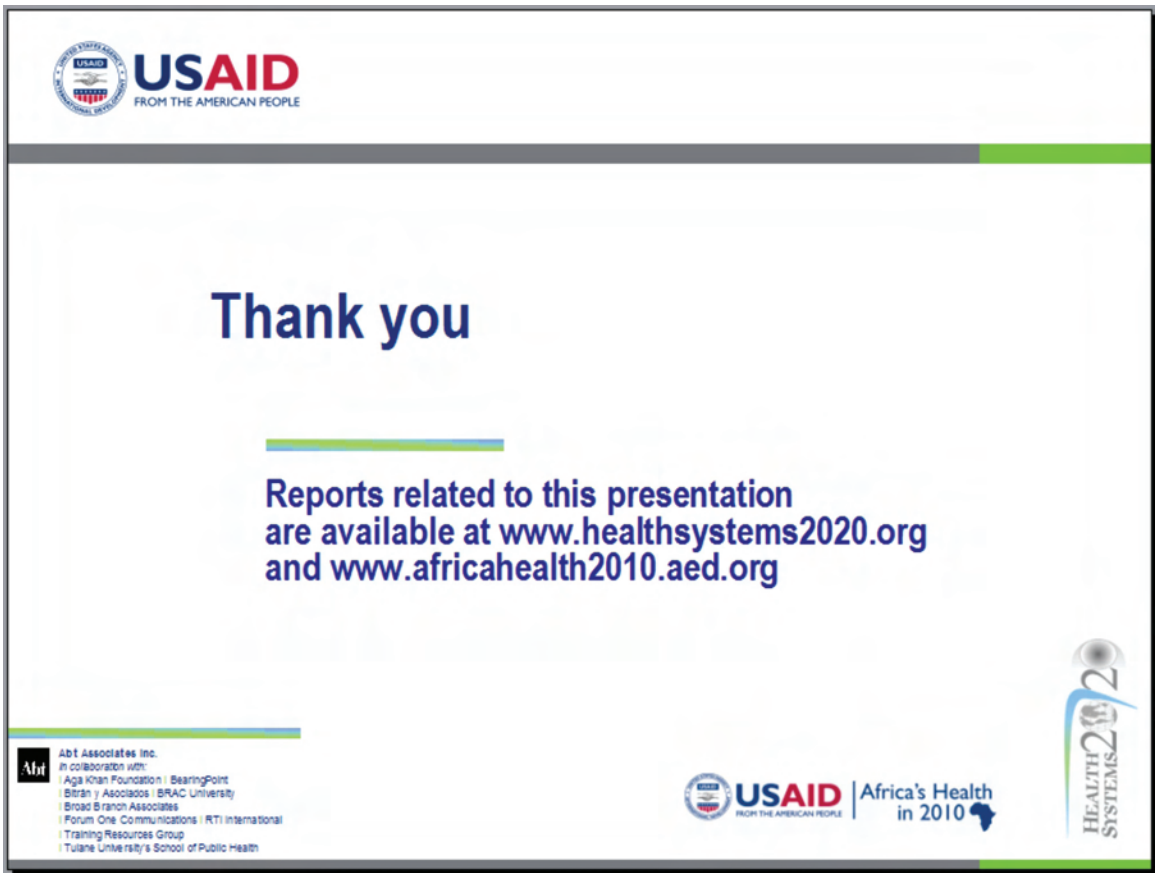
Populating the matrices; Some tips *cont'd*

- From time to time, step back and check whether numbers seem reasonable
  - e.g., Make sure that what donors report for RH is not greater than what they report for overall health care

18

Take home message

- There are basically two steps in data analysis
  - T-account/data summary computation for each major entity
  - Population of the matrices
- Start with financing agents
  - You can go forward (uses) and backwards (sources)
  - Fewer HFs, therefore relatively easy to capture
  - Data pertaining to HFs is the soundest, and thus the strongest dimension of NHA
- Need much more than just expenditure data for NHA data analysis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Unit 6b:
RH-specific Data Analysis Issues

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2

Learning objectives

- Be familiar with and know how to address
  - Boundary-related issues
    - Between other subaccounts
    - Between health and health-related
  - Commodity-related issues
- Be familiar with approaches for estimating
  - non-targeted spending

3

Why do boundary-issues feature so prominently in subaccounts?

- Challenges to measuring "disease-specific/intervention-specific"
  - Health resources are shared
    - not usually allocated to a single program area
  - Health interventions & programs may address multiple conditions concurrently
  - The same product is generated for two or more programmes ("joint product")
  - Most expenditure records do not report on specific diagnoses
- Reported expenditures encompass broad categories/ integrated areas rather than disease/intervention-focused services.

4

Why do boundary-issues feature so prominently in subaccounts? Cont'd

- Traditional accounting says
  - Each transaction be reported only once
    - And placed in the category with the largest weight
  - The total amount, which may extend beyond targeted boundaries, should be allocated to principal purpose
  - Problem: then have sizeable overestimates for RH subaccounts

5

Why do boundary-issues feature so prominently in subaccounts? Cont'd

- NHA says
  - To maintain policy relevance, RH subaccounts should aim to capture, to extent possible, only the amount spent on RH activities
  - May mean "dicing" of integrated transactions
    - Keep this to a minimum (is a "guesstimate")
    - Do only when full value of integrated spending is a gross estimate
    - Identify appropriate allocation factors to split the expenditure, based on "key" reference values (share of human resource, utilization, cost, etc. avoid the use of population)

6

Overlaps with other subaccounts

- Can happen with Malaria, Child health, and HIV/AIDS
  - E.g. Intermittent Preventive Therapy and Antimalarial chemoprophylaxis (given to pregnant mothers for malaria prevention)
  - There are international recommendations on where overlapping activities should be placed
  - These may or may not coincide with domestic policy needs.
    - When they differ, areas of overlap should be clearly identified
      - so that adjustments may be made for international comparison purposes

7

Example of overlapping services among RH and other subaccounts types

Overlapping services	Subaccounts that could possibly include overlapping services with the RH subaccounts			
	RH subaccount	CH subaccount	HIV/AIDS subaccount	Malaria Subaccount
Services addressing Sexually Transmitted Infections	X		X	
HIV/AIDS services	X		X	
Prevention of Mother To Child Transmission for HIV/AIDS	X		X	
Intermittent Preventive Therapy and Antimalarial chemoprophylaxis (given to pregnant mothers for malaria prevention)	X			X
Newborn health care (in perinatal period)	X	X		

8

What to do in cases of Subaccounts overlaps?

- Ideally, expenditure estimates on such activities should not be repeated in two or more subaccount types. If it overlaps in two subaccounts, usually it should be captured in the subaccount with the largest policy influence and agreed upon by stakeholders – clearly labeled and identified.
- If the estimates do span 2 or more accounts particularly when conducted simultaneously, expenditures should be divided among the various subaccounts. This allows for the sum of the part (i.e. subaccounts) to add up to the whole (THE).
- Care should be taken to not double count those services that may overlap with other subaccounts, and to clearly label them, so that adjustments may be made to ensure comparability of 'apples and apples.'

9

Contraceptive Commodities related issues

- Issue: How to estimate oop spending when expenditure information is not available?
- Approach: We rely on cost and use data. A product of use and annualized cost data will give an estimate of total hhld out of pocket expenditure for the type of commodity.
- The DHS usually provides the number of women who use a given contraceptive by provider type; cost at which the commodity is sold to patients can be determined from various provider types; annualize the expenditure estimate

10

Commodity related issues and approaches contd.

- Issue: How to account for commodities that may be purchased more than once
- Approach: See PG for out of pocket spending – always record the full value of household oop spending at the provider level.
- For institutional spending – assess what happens to generated revenue. (for e.g. Is it retained at the facility, or returned to MOH, or is it stored in a bank account)

11

Dealing with non-targeted spending

- Targeted spending to RH i.e. by MoH, donors, NGOs, HH OOP
- Non-targeted spending: expenditures on activities not earmarked for producing RH services at non-market providers
  - Incl. Medical staff wages for staff to deal with RH patients
  - These costs are essentially covered from the provider's general revenue (contributed by HF for all health services rendered by the provider)
- Generally the largest share of RH clinical activities is non-targeted.
  - Usually this element is not detailed in provider records

12

Dealing with non-targeted spending cont'd

- Assume that a certain proportion of overall provider expenditures goes towards non-targeted RH spending.
  - % can be derived from
    - RH costing studies at hospitals and health centers
    - Billing records for OOP of hospital discharges
    - From records of commodity distribution by government
    - From utilization records of the number of OP and IP visits attributed to RH services and goods.
  - To determine which financing agents contribute to non-targeted spending, use the same ratios of contributors for overall health care at that provider

13

Dealing with non-targeted spending cont'd

- **In Rwanda, used a combination of cost and use data to derive %.**

$$\frac{\text{Average cost per admission for a RH related service at public hospitals} \times \text{Number of patient days for RH care at public hospitals}}{\text{Average cost overall per admission at public hospitals} \times \text{Number of patient days for all care at public hospitals}} = \text{Z \% of overall IP expenditures that are used for RH care}$$

14

Relying on cost and use data to derive expenditures

- Non-market production
  - Prices are not available for non-market production, then use costs – but do so cautiously
    - Because unit cost is often based on "ideal" or full set of services rendered.
    - To the extent that services are inefficiently provided, cost estimates will be different than efficiently delivered services.
    - Thus, often cost data differs greatly from expenditure.
  - OK for commodity expenditures

15

Take home message

- Good data leads to good decisions.
- To estimate a subaccount, you need more than just expenditure data
- The process can be time-consuming at times. Be prepared.
- It is critical to document all your assumptions and approaches:
  - so that the following year, you can refer to them or improve upon them

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Unit 6c:
Data Analysis Case Study

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2

Learning objectives

At the end of this unit participants will:

- Be familiar with the types of data needed for the analysis phase
- Understand the basic tasks inherent in analysis
- Become aware of the guiding principles and tips when populating NHA matrices.

3

Application questions

- There are several tasks listed that relate to the Ovaria case-study
- You will be given time to complete each task individually - although you may discuss and help others
- After the completion of each task, we will go over the answers together as a class

4

Case-study set-up

- You are part of the NHA team in Ovaria, a small country in Pacific
  - Its capital is perhaps not-surprisingly called Eggelston
  - The currency is $
  - The year of NHA estimation is 2004
  - Reproductive health (RH) related illnesses are the leading cause of morbidity and mortality
- Response to RH
  - Major financiers: donors, govt and HH
  - All MoF funds given to non-MoH entities are from a USAID grant
  - Mixture of providers: public, semi-public (govt assisted not-for profit (NGO) sponsored), and private providers

5

Case-study set-up cont'd
Additional information from costing studies

Cost of average RH IP visit	$	125.00
Cost of average RH OP visit	$	40.00
Cost of avearge general IP visit	$	100.00
Cost of average general OP visit	$	25.00
Number of RH IP patient days per month	$	300.00
Number of RH OP visits per month	$	400.00
Number of general IP patient days per month	$	2,000.00
Number of general OP visits per month	$	1,500.00

6

Case-study set-up

- Your preparatory research reveals the following ratios:
  - Overall, 70% of public facility expenditure is incurred at public hospitals
  - The HMIS shows that at public hospitals, health expenditures are largely incurred on IP care (65%) versus OP care (35%)
- In the public sector prevention and treatment of all infectious diseases for pregnant women is administered through the RH program
- Recent costing and utilization study indicates prenatal care per visit costs $5.00 and postnatal care per visit costs $3.00. Other information: 50% of all visits are for MH, 30% for CH and 20% for other services. Of the MH visits 80% are for prenatal care and 20% for post natal care

7

Case study set up cont'd

You find the following information concerning service delivery in the National RH and FP strategic program 2004 annual report:

	Public sector (receives all its funds for condoms from USAID)	Private sector (receives its condoms from PSI)
Number of condoms sold	170,000,000	25,000,000
Unit cost to HH per condom	1.7	1.8
Providers that distribute condoms	Public hospitals and public health centers	Shops and pvt. Pharmacies

8

Task 1

- You are provided with an illustrative NGO data set concerning NGO responses to the question "what expenditures did you incur for each of your projects and who was the recipient of these funds?" (Table 1)
- Your task is to
  - Classify the expenditures using the scheme that was developed at an earlier country NHA training. Note: if more than one provider is specified, you will need to apportion the total amount reported across the various provider recipients

9

Task 1a)

Table 1: NGO survey data set on how funds are spent.

Q.	NGO name	Project Title	Project description	Recipient	Amount
A	PSI International	HIV/AIDS Prevention	Distribution of condoms	Public Health Centers	76,000,000
B	PSI International	Social marketing of oral contraceptives	Oral contraceptives procurement and distribution	Shops, private pharmacies	100,986,000
C	PSI International	Strengthening the community response to FGM	Training of community health workers on FGM messages	Community health care workers	18,983,621
D	Save the children	MCH care	Distribution of pre-natal vitamins and folic acid supplements	Public hospitals, health centers	9,717,698
E	Save the children	Reducing childhood morbidity	Distribution of IPT drugs for pregnant women and children	Public hospitals	4,591,166
F	Engender Health	Scaling up MCH services	Post partum care and IMCI	NGO hospitals	3,849,665

10

Task 1a) Answer

Q.	NGO name	Project Title	Project description	Recipient	Amount	Revised amounts across HP and HC	HP classification	HC classification
A	PSI International	HIV/AIDS Prevention	Distribution of condoms	Public Health Centers	76,000,000	76,000,000	Exclude	Exclude
B	PSI International	Social marketing of oral contraceptives	Oral contraceptives procurement and distribution	Shops, private pharmacies	100,986,000	100,986,000	HP.4.1	HC.5.1.1
C	PSI International	Strengthening the community response to FGM	Training of community health workers on FGM messages	Community health care workers	18,983,621	18,983,621	HP.3.3	HC.6.1.1
D	Save the children	MCH care	Distribution of pre-natal vitamins and folic acid supplements	Public hospitals, health centers	9,717,698	6,802,389	HP.1.1.1	HC.1.3.9
						2,915,309	HP.3.4.5.1	HC.1.3.9
E	Save the children	Reducing childhood morbidity	Distribution of IPT drugs for pregnant women and children	Public hospitals	4,591,166	4,591,166	HP.1.1.1	HC.1.3.9
F	Engender Health	Scaling up MCH services	Post partum care and IMCI	NGO hospitals	3,849,665	2,406,041	HP.1.1.2.1	HC1.3.10

11

Task 2 a): Multiple-purchases of commodities

- Scenario A: **when full value distributed free of charge**
  - Donors give $100 for the purchase of condoms.
  - MoH uses these funds in their entirety to purchase and distribute condoms (valued at $100) free of charge to its providers
  - The Providers in turn dispense them to patients free of charge.
    - How should this be presented in NHA tables?

FSxHF	FS 3. Rest of the world	Total
HF.1.1.1.1 Ministry of Health	$100	*$100*
Total	*$100*	
HFxHP	**HF.1.1.1.1 Ministry of Health**	**Total**
HP.1.1.1. Public hospitals	$50	*$50*
HP.3.4.5.1 Public Health Centers	$50	*$50*
Total	*$100*	*$100*

Illustrative split at the provider level

12

Task 2b) Multiple-purchases of commodities

- Scenario B: when fully donated goods are ultimately dispensed to HH for a fee which is retained at facility level.
  - Same as Scenario A except - providers dispense condoms to patients for $10 fee. This is then retained at facility
    - How should this be presented in NHA tables?

FSxHF	FS 3. Rest of the world	FS 2.2 Households	Total
HF.1.1.1.1 Ministry of Health	$100		*$100*
HF.2.3 HH OOP		$10	$10
Total	*$100*	$10	*$110*
HFxHP	**HF.1.1.1.1 Ministry of Health**	**HF 2.3 HH OOP**	**Total**
HF.1.1.1. Public hospitals	$50	$3	*$53*
HF.3.4.5.1 Public Health Centers	$50	$7	*$57*
Total	*$100*	*$10*	*$110*

* Table below is Illustrative assumption of HH OOP breakdown across providers

13

Task 2c) Multiple-purchases of commodities

- Scenario C: when funds are donated but not used to purchase condoms
  - Donors give MoH $100 for the purchase of condoms
  - MoH does not use the funds and retains it in its bank account.
  - How should this be presented in NHA tables?
    - EXCLUDED from subaccounts that year, but included in subsequent year(s) if those funds are used and spent on RH related activities

14

Task 2d) Multiple-purchases of commodities

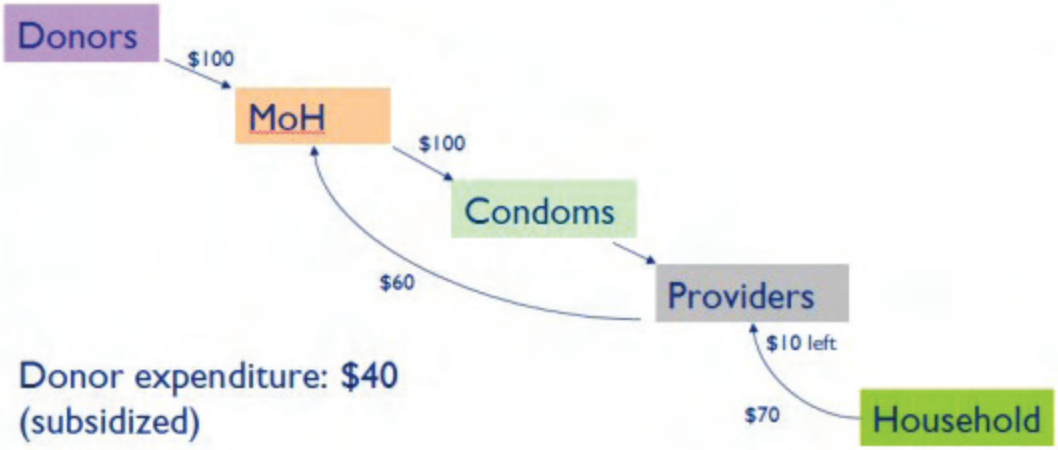
- Scenario D: **when donated goods are sold to public providers, which in turn sell to patients for a fee**
  - Donors give $100 for the purchase of condoms.
  - MoH uses these funds in their entirety to purchase the condoms (valued at $100) and then sells to its health centers for $60
  - The $60 amount is stored in MoH bank account until next year.
  - HHs buy condoms from facilities for $70.
    - How should this be presented in NHA tables?

FSxHF	FS.2.2 Households	FS.3 Rest of the World (donors)	Total
HF. 1.1.1.1 MoH		40	40
HF 2.3 Households Out-of-pocket	70		70
Total	70	40	110

HFxHP	HF 1.1.1.1 MoH	HF 2.3 Households OOP	Total
HP.3.4.5.1 Public health centers*	40	70	110
Total	40	70	110

15

Accounting for expenditures on commodities



Donor expenditure: $40 (subsidized)

HH OOP: $70

Total spent on Condoms= $110

16

Task 2e) Multiple-purchases of commodities

- Scenario E: **when donated goods are sold in private sector**
  - Donors give NGOs $100 for the purchase of condoms.
  - NGOs use full amount to purchase condoms and sell to shops for $60. The amount raised by NGOs is used for next year's packaging and distribution of condoms.
  - Shops sell all of their condoms to HH for $80.
  - How should this be presented in NHA tables?

FSxHF	FS.2.2 Households	FS.3 Rest of the World (donors)	Total
HF. 2.4 NPISH		40	40
HF 2.3 Households Out-of-pocket	80		80
Total	80	40	120
HFxHP	**HF 2.4 NPISH**	**HF 2.3 Households OOP**	**Total**
HP4.1 Dispensing chemists	40	80	120
Total	40	80	120

17

Task 3

- Estimate NATIONAL OOP spending on condoms by provider and by function? Fill out table below. (Hint: Need to look back at the case study set-up)

Out of Pocket spending on condoms by provider by function

Provider	OOP Amount	Function
Public		
Hospital Pharmacy		
Health Center Pharmacy		
Private		
Dispensing Chemists		

18

Task 3) ANSWER

- Go back to the case study set up
  - Since it provides unit cost and use data, simply multiply the two to get expenditure
    - Therefore National OOP spending on condoms is:
      - Public sector= 1.7*170,000,000= 289,000,000
      - Private sector=25,000,000*1.8 = 45,000,000
    - When broken down by provider and function

Out of Pocket spending on condoms by provider by function

Provider	OOP Amount	Function
Public		
Hospital Pharmacy	**202,300,000**	**HC 1.3.y**
Health Center Pharmacy	**86,700,000**	**HC.1.3.y**
Private		
Dispensing Chemists	**45,000,000**	**HC 5.1.3**

19

Task 4a)

- Because you have done a general NHA , you have the following breakdown regarding each provider's revenue.

From the general NHA tables	
$5,000	Targeted spending on RH (all comes from NGOs)
$20,000	General provider revenue
$15,000	IP revenue: MoH contributes 7500: NGOs 7000: HH 500
$5,000	OP revenue: MoH contributes 3000: HH 2000

Question 4 a: How much of general provider revenue is untargeted for RH (in addition to the targeted amounts)?

20

Answer 4a

Y% for IP care that is untargeted for RH = 18.75%

(125x300) / (100x2000)

Y% for OP care that is untargeted for RH = 42.67%

(40x400) / (125x1500)

Answer to question 4a

Amount untargeted for RH IP (18.75% of 15,000)	$2,813
Amount untargeted for RH OP (42.67% of 5,000)	$2,133
TOTAL	**$4,946**

21

Task 4b)

- Now that you know the untargeted amount for RH, how should this be entered in the HF x HP table?

22

Task 4b answer

HF xHP table	HF		
HP	NGOs	MoH	HH
Semipublic hospital (targeted)--5,000	$ 5,000		
Semipublic hospital (untargeted)--4,946	$ 1,313	$ 2,686	$ 947

Final HF XHP table should look like the following:

HP	NGOs	MoH	HH
Semipublic hospital (targeted)--5,000	$ 6,313	$ 2,686	$ 947

23

Task 4c (last task!)

- Why is this non-target estimation not done for market providers?

24

Take home message

- Always check the primary purpose of reported expenditure
- Remember your boundaries
- Avoid when possible the "dicing" of integrated activities
  - **To preserve expenditure data and to curtail "guesstimates"**
  - **Dicing is OK when full value of integrated activity is likely to be a significant overestimate**
- Commodities: what is important is the end use of OOP funds and whether or not they are used at the facility level.
- As information systems improve and data collection routine, you will rely less and less on estimation techniques and more on actual "un-manipulated" expenditure data

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Unit 6 - Exercises

This case study simulates some of the data analysis that you may face in your experience while completing the RH subaccounts. It entails solving a series of 4 tasks – you will be given time to resolve each one of them.

Case-study setup

- You are part of the NHA team in Ovaria, a small country in Pacific
  - Its capital is perhaps not-surprisingly called Eggelston
  - The currency is $.
  - The year of NHA estimation is 2004.
  - Reproductive health (RH) related illnesses are the leading cause of morbidity and mortality
- Response to RH:
  - Major financiers: donors, gov, and HH.
  - All MoF funds given to non-MoH entities are from a USAID grant.
  - Mixture of providers: public, semi-public (gov. assisted not-for profit (NGO) sponsored), and private providers.

Additional information is provided to you from a costing study that was previously conducted in your country.

Cost of average RH IP visit	$125
Cost of average RH OP visits	$ 40
Cost of average general IP visit	$100
Cost of average general OP visit	$ 25
Number of RH IP patient days per month	300
Number of RH OP visits per month	400
Number of general IP patient days per month	2000
Number of general OP visits per month	1500

Refer to your RH ICHA handout as and when necessary for answering the questions.

- Your preparatory research reveals the following ratios:
  - Overall, 70% of public facility expenditure is incurred at public hospitals
  - The HMIS shows that at public hospitals, health expenditures are largely incurred on IP care (65%) versus OP care (35%)

- In the public sector prevention and treatment of all infectious diseases for pregnant women is administered through the RH program
- Recent costing and utilization study indicates prenatal care per visit costs $5.00 and postnatal care per visit costs $3.00. Other information: 50% of all visits are for MH, 30% for CH and 20% for other services. Of the MH visits 80% are for prenatal care and 20% for post natal care.

You find the following information concerning service delivery in the National RH and FP strategic program 2004 annual report:

	Public sector (which receives all its funds for nets from UNICEF)	**Private sector (receives its condoms from PSI)**
Number of condoms sold	170,000,000	25,000,000
Unit cost to HH per condom	1.7	1.8
Providers that distribute condoms	Public hospitals and public health centers	Shops and pvt. Pharmacies

Task 1

You are provided with an illustrative NGO data set concerning NGO responses to the question "what expenditures did you incur for each of your projects and who was the recipient of these funds?" (Table 1)

Your task is to: Classify the expenditures using the scheme that was developed at an earlier country NHA training.

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Cost of average RH OP visits	$ 40
Cost of average general IP visit	$100
Cost of average general OP visit	$ 25
Number of RH IP patient days per month	300
Number of RH OP visits per month	400
Number of general IP patient days per month	2000
Number of general OP visits per month	1500

Details on answer Task 1 a:

Calculations:

Table 1

Task 2: Multiple-purchases of commodities

Task 2a: When full value is distributed free of charge

- Donors give $100 for the purchase of condoms.
- MoH uses these funds in their entirety to purchase and distribute condoms (valued at $100) free of charge to its providers.
- The Providers in turn dispense them to patients free of charge.
- How should this be presented in NHA tables?

Details on answer Task 2 a:

Calculations:

Task 2 b: When fully donated goods are ultimately dispensed to HH for a fee which is retained at facility level.

- Same as Scenario A except - providers dispense condoms to patients for $10 fee. This is then retained at facility.
- How should this be presented in NHA tables?

Details on answer Task 2b:

Calculations

Task 2c: When funds are donated but not used to purchase condoms

- Donors give MoH $100 for the purchase of condoms.
- MoH does not use the funds and retains it in its bank account.
- How should this be presented in NHA tables?

Details on answer Task 2c:

Calculations

Task 2d: When donated goods are sold to public providers, which in turn sell to patients for a fee

- Donors give $100 for the purchase of condoms.
- MoH uses these funds in their entirety to purchase the condoms (valued at $100) and then sells to its health centers for $60
- The $60 amount is stored in MoH bank account until next year.
- HHs buy condoms from facilities for $70.
- How should this be presented in NHA tables?

Details on answer Task 2d:

Calculations

Task 2e: When donated goods are sold in private sector

- Donors give NGOs $100 for the purchase of condoms.
- NGOs use full amount to purchase condoms and sell to shops for $60. The amount raised by NGOs is used for next year's packaging and distribution of condoms.
- Shops sell all of their condoms to HH for $80.
- How should this be presented in NHA tables?

Details on answer Task 2e:

Calculations

Task 3: Estimate NATIONAL OOP spending on condoms by provider and by function? Fill out table below. (Hint: Need to look back at the case study set-up)

Calculations

Out-of-Pocket spending on condoms by provider by function		
Provider	**OOP Amount**	**Function**
Public		
Hospital Pharmacy		
Health Center Pharmacy		
Private		
Dispensing Chemists		

Task 4:

Because you have done a general NHA, you have the following breakdown regarding each provider's revenue.

From the general NHA tables		
	$ 5,000	Targeterd spending on RH (all comes from NGOs)
	$ 20,000	General provider revenue
	$ 15.000	IP revenue: MoH contribute 7500, NGOs 7000, HH 500
	$ 5,000	OP revenue: MoH contribute 3000, HH 2000

Task 4 a: How much of general provider revenue is untargeted for RH (in addition to the targeted amounts)?

Answers to Task 4a

Calculations

Task 4b: Now that you know the untargeted amount for RH, how

should this be entered in the HF x HP table?

Answers to Task 4b

Calculations

Task 4c: Why is this non-target estimation not done for market providers?

Answers to Task 4c

Calculations

Unit 6 - Answers

This case study simulates some of the data analysis that you may face in your experience while completing the RH subaccounts. It entails solving a series of 4 tasks – you will be given time to resolve each one of them.

Case study set up:

- You are part of the NHA team in Ovaria, a small country in Pacific
  - Its capital is perhaps not-surprisingly called Eggelston
  - The currency is $
  - The year of NHA estimation is 2004
  - Reproductive health (RH) related illnesses are the leading cause of morbidity and mortality
- Response to RH
  - Major financiers: donors, govt and HH
  - All MoF funds given to non-MoH entities are from a USAID grant
  - Mixture of providers: public, semi-public (govt assisted not-for profit (NGO) sponsored) , and private providers.

Cost of average RH IP visit	$125
Cost of average RH OP visits	$ 40
Cost of average general IP visit	$100
Cost of average general OP visit	$ 25
Number of RH IP patient days per month	300
Number of RH OP visits per month	400
Number of general IP patient days per month	2000
Number of general OP visits per month	1500

Additional information is provided to you from a costing study that was previously conducted in your country.

Refer to your RH ICHA handout as and when necessary for answering the questions.

- Your preparatory research reveals the following ratios:
- Overall, 70% of public facility expenditure is incurred at public hospitals
- The HMIS shows that at public hospitals, health expenditures are largely incurred on IP care (65%) versus OP care (35%)
- In the public sector prevention and treatment of all infectious diseases for pregnant women is administered through the RH program
- Recent costing and utilization study indicates prenatal care per visit costs $5.00 and postnatal care per visit costs $3.00. Other information: 50% of all visits are for MH, 30% for CH and 20% for other services. Of the MH visits 80% are for prenatal care and 20% for post natal care.

You find the following information concerning service delivery in the National RH and FP strategic program 2004 annual report:

	Public sector (which receives all its funds for nets from UNICEF)	**Private sector (receives its condoms from PSI)**
Number of condoms sold	170,000,000	25,000,000
Unit cost to HH per condom	1.7	1.8
Providers that distribute condoms	Public hospitals and public health centers	Shops and pvt. Pharmacies

Task 1

You are provided with an illustrative NGO data set concerning NGO responses to the question "what expenditures did you incur for each of your projects and who was the recipient of these funds?" (Table 1)

Your task is to: Classify the expenditures using the scheme that was developed at an earlier country NHA training.

Details on answer Task 1 :

NGO Name	Project Title	Project Description	Recipient	Amount	Revised Amount across HP and HC	HC Classifi-cations	HC Classifi-cations
A. PSI International	HIV/AIDS prevention	Distribution of condoms	Public health centers	76.000.000	76.000.000	Exclude	Exclude
B. PSI International	Social marketing of oral contraceptives	Oral contraceptives procurement and distribution	Shops, private pharmacies	100,986,000	100,986,000	HP 4.1	HC 5.1.1
C. PSI International	Strengthening the community response to FGM	Training of community health workers on FGM messages	Community health workers	18,983,621	18,983,621	HP 3.3	HC 6.1.1
D. Save the Children	MCH care	Distribution of prenatal vitamins and folic accid supplements	Public hospitals, health centers	9,717,698	6.802,389	HP 1.1.1	HC 1.3.9
					2,915.309	HP 3.4.5.1	HC 1.3.9
E. Save the Children	Reducing childhood morbidity	Distribution of IPT drugs for pregnant women and children	Public hospitals	4,591,166	4,591,166	HP 1.1.1	HC 1.3.9
F. Engender Health	Scaling-up MCH services	Post partum care and IMCI	NGO hospitals	3,849,665	2.406,041	HP 1.1.2.1	HC 1.3.10

Calculations:

1) $76,000,000 is excluded because as the description of the project indicates, these condoms are a part of HIV/AIDS prevention activity and not RH, therefore should be excluded from RH subaccounts

2) Save the children funds : $9,717,698 is split between two providers. See the case study set up. It is given that the 70% of public expenditures are incurred at public hospitals and 30% at the health centers. Distribute this amount in that ratio (7:3) between the two providers

3) Note that for the IPT drugs for pregnant women (OP care) to prevent Malaria. While going through the answers highlight that this is tricky boundary issue. However, note that in in the case study set-up we are told that it is considered as part of the RH program. So you will need to create new HC code and clearly label it as IPT, in case, we need to separate it later on as a Malaria expenditure instead.

4) EngenderHealth amount: First, check with EngenderHealth if they have a record of how much they spend on MH care vs child health care. If they don't know that distribution, do the following:
   - See the information given in the case study setup: 50 percent of all visits are for MH, 30 percent for CH and, 20 percent for other services. Only include the MH proportion.

Task 2: Multiple-purchases of commodities

Task 2a: When full value is distributed free of charge

- Donors give $100 for the purchase of condoms.
- MoH uses these funds in their entirety to purchase and distribute condoms (valued at $100) free of charge to its providers.
- The Providers in turn dispense them to patients free of charge.
- How should this be presented in NHA tables?

Details on answer Task 2 a:

FS x HF	FS 3. Rest of the World	Total
HF 1.1.1.1 Ministry of Health	$100	$100
Total	$100	$110

HF x HP	HF 1.1.1.1 Ministry of Health	Total
HF 1.1.1 Public Hospitals	$ 50	$ 50
HF 3.4.5.1 Public Health Centers	$ 50	$ 50
Total	$100	$110

Calculations:

Task 2 b: When fully donated goods are ultimately dispensed to HH for a fee which is retained at facility level.

- Same as Scenario A except - providers dispense condoms to patients for $10 fee. This is then retained at facility.
- How should this be presented in NHA tables?

Details on answer Task 2b:

FS x HF	FS 2.2 Households	FS 2. Rest of the World (donors)	Total
HF 1.1.1.1 MoH		$ 40	$ 40
HF 2.3 HH OOP	$ 70		$ 70
Total	$ 70	$ 40	$110

HF x HP	HF 1.1.1.1 MoH	HF 2.3 HH OOP	Total
HF 3.4.5.1 Public health centers	$ 40	$ 70	$110
Total	$ 40	$ 70	$110

Illustrative split at the provider level – just an example.

Calculations

1. What is critical is the 'end use" of HH OOP revenue. Since funds were used for health care and most likely during year of estimation, treat like the PG approach for user fee retention at the government facility level.
2. In such cases, the PG states that "if the (user) fees are retained as additional resources by providers, i.e. supplement ministry of health spending they do not need to be subtracted from the Ministry total" (p.142 paragraph 10.15). Therefore the full donor and household contributions are additive.
3. **DISCUSSION Question:** To NHA experts primarily: What if household userfees were returned to the Ministry of Health, then the recorded MoH expenditure will be a net of those fees. So $100-$10= $90. As stated in the PG, "it is essential that they not be included in the ministry's outlays in order to avoid double counting those expenditures."(p.142 paragraph 10.15). Consequently, tracing the expenditure back to the financing source level, donors would be recorded as giving $90 to the MoH.
4. Note: regardless of the end use of OOP revenue, the full value of HH OOP payments should be recorded in health accounts.

Task 2c: When funds are donated but not used to purchase condoms

- Donors give MoH $100 for the purchase of condoms.
- MoH does not use the funds and retains it in its bank account.
- How should this be presented in NHA tables?

Details on answer Task 2c:

EXCLUDED from subaccounts that year, but included in subsequent year(s) if those funds are used and spent on RH related activities.

Calculations

Task 2d: When donated goods are sold to public providers, which in turn sell to patients for a fee

- Donors give $100 for the purchase of condoms.
- MoH uses these funds in their entirety to purchase the condoms (valued at $100) and then sells to its health centers for $60
- The $60 amount is stored in MoH bank account until next year.
- HHs buy condoms from facilities for $70.
- How should this be presented in NHA tables?

Details on answer Task 2d:

FS x HF	FS 2.2 Households	FS 2. Rest of the World (donors)	Total
HF 1.1.1.1 MoH	$100		$100
HF 2.3 HH OOP		$ 10	$ 10
Total	$100	$ 10	$110

HF x HP	HF 1.1.1.1 MoH	HF 2.3 HH OOP	Total
HF 1.1.1 Public hospitals	$ 50	$ 3	$ 53
HF 3.4.5.1 Public health centers	$ 50	$ 7	$ 57
Total	$100	$ 10	$110

Calculations

1. Consider the end use of donor monies: not used that year in health system. Therefore, excluded from this year's accounts. So donor amount given is actually only $40.
2. Consider end use of OOP revenue: Retained at facilities, then should be counted the same as scenario b

Task 2e: When donated goods are sold in private sector

- Donors give NGOs $100 for the purchase of condoms.
- NGOs use full amount to purchase condoms and sell to shops for $60. The amount raised by NGOs is used for next year's packaging and distribution of condoms.
- Shops sell all of their condoms to HH for $80.
- How should this be presented in NHA tables?

Details on answer Task 2e:

FS x HF	FS 2.2 Households	FS 2. Rest of the World (donors)	Total
HF 2.4 NPISH		$ 40	$ 40
HF 2.3 HH OOP	$ 80		$ 80
Total	$ 80	$ 40	$120

HF x HP	HF 2.4 NPISH	HF 2.3 HH OOP	Total
HP 4.1 Dispensing chemists	$ 40	$ 80	$120
Total	$40	$ 80	$120

Calculations

1. Again, always record households as is.
2. With respect to donor contribution- treat it similar to scenario C. NGO is like the MoH. Shops are like public providers- they send part of their user fee revenue back to NGO (similar to MoH). Thus, that amount has to be deducted from NGO contribution to shops. To avoid double counting.

Task 3: Estimate NATIONAL OOP spending on condoms by provider and by function? Fill out table below.

(Hint: Need to look back at the case study set-up)

Out-of-Pocket spending on condoms by provider by function		
Provider	**OOP Amount**	**Function**
Public		
Hospital Pharmacy		
Health Center Pharmacy		
Private		
Dispensing Chemists		

Answer Task 3:

Out-of-Pocket spending on condoms by provider by function		
Provider	**OOP Amount**	**Function**
Public		
Hospital Pharmacy	202,300,000	HC 1.3.y
Health Center Pharmacy	85,700,000	HC 1.3.y
Private		
Dispensing Chemists	45,000,000	HC 5.1.3

To fill out the tables: you have to estimate values for the OOPxPublic hospital cell, OOPxpublic health center cell, and OOP x dispensing chemists cell

Remember the information from the case study set up. 70 percent of public expenditures occur at the hospitals. Apply the same proportion here to divvy the public sector amount between hospital pharmacy and health center pharmacy. (289,000,000) x 0.7 to Hospitals and rest to health center pharmacy.

The HC 1.3.y code – where "y" designates a more specific category of "condoms rendered as part of OP visit"

Task 4:

Because you have done a general NHA, you have the following breakdown regarding each provider's revenue.

From the general NHA tables		
	$ 5,000	Targeterd spending on RH (all comes from NGOs)
	$ 20,000	General provider revenue
	$ 5.000	IP revenue: MoH contribute 7500, NGOs 7000, HH 500
	$ 5,000	OP revenue: MoH contribute 3000, HH 2000

Task 4 a: How much of general provider revenue is untargeted for RH (in addition to the targeted amounts)?

Answers to Task 4a

Answer to question 4 a

$2,813 (amount untargeted for RH IP) (18.75% of $15,000)
$2133 (amount untargeted for RH OP(42.67% of 5000)
$4,946 Total

Calculations

Refer to case study set up slide that gives you average cost per visit and average number of OP visits and average no. of patient days per month. Using that information calculate the following:

Y% for IP care that is untargeted for RH= 18.75% (125x300)/(100x2000)

Y% for OP care that is untargeted for RH= 42.67% (40x400)/(25x1500)

Task 4b: Now that you know the untargeted amount for RH, how should this be entered in the HF x HP table?

Answers to Task 4b

HF x HP table	HF		
HP	NGOs	MoH	HH
Semipublic hospital (targeted) - 5,000	$5,000		
Semipublic hospital (targeted) - 5,000	$1,313	$2,686	$ 947

Final HF x HP table should look like the following:

HP	NGOs	MoH	HH
Semipublic hospital (targeted) - 5,000	$6,313	$2,686	$ 947

Calculations

From the case study setup, we know.

Task 4c: Why is this non-target estimation not done for market providers?

Answers to Task 4c

It should be noted that the full cost of intermediate inputs (including salaries, equipment, supplies) at private-for-profit providers is embedded within the price charged to patients or insurance schemes. Thus, non-targeted expenditures do not need to be estimated separately in these cases.

Calculations

Unit 6 - Handout

RH Case Study Codes

NHA Code	Description
HF.1.1.1	MoH (MiniSante)
HF.1.1.2	DSGAS (includes districts)
HF.1.1.3	Other Ministries
HF.1.2	Social Security Fund (CSR-Caisse Sociale*)
HF.2.1.1	Gov't Employees insurance programs - RAMA (Rwanda medical insurance)
HF.2.5.1	Parastatals
HF.2.2	Private Insurance Enterprises (other than social insurance)- Mutuelles, FARG
HF.2.3.	Private household out of pocket payments
HF.2.4	NPISH (other than social insurance)
HF.2.5	Private firms and corporations (other than health insurance)
HF.3	Rest of World
HF.nsk	Not specified by any kind
	Column Total (THE)
HF.4	Financing Agents spending on Health Related Items
NHE	**Non health expenditures included**

NHA Code	Description
FS.1	Public Funds
FS.1.1	Central Gov Revenue
FS.1.1.1	Central government revenue
FS.1.1.2	Regional and municipal government revenue
FS.1.2	Other public funds
FS.2	Private Funds
FS.2.1.1	Parastatal Employer Funds (e.g. ELECTROGAZ)
FS.2.1.2	Private Employer Funds
FS.2.2	Households
FS 2.3	NPISH (NGOs Local)
FS 2.4	Other Private Funds
FS. 3	Cooperating Partners (Rest of the world)
HF.nsk	Not specified by any kind

NHA Code	Description
HP.1.1.1	Public Hospitals
HP.1.1.2.1	Gov't assisted not-for-profit hospitals
HP.1.1.2.2	Private hospital for-profit
HP.3.1	Offices of physicians (private clinics)*
HP.3.3	Offices of other health practitioners
HP.3.4.1	Family planning centers
HP.3.4.5.1	Public health centers (including ARBEF clinics)
HP.3.4.5.2	Private not-for-profit health centers
HP.3.5	Medical and diagnostic laboratories
HP.4.1	Dispensing chemists (incl. Shops)
HP.5	Provision and admin of public health programs
HP.6	General health administration and insurance
HP.6.1	Government administration of health
HP.6.3	Other insurance administration (RAMA)
HP.nsk	Providers not specified by any kind

7

Unit 7

Implementation Process for Reproductive Health Subaccounts

Time

60 minutes

Learning Objectives

- Recognize what is entailed in conducting the subaccount estimation
  - Concurrently with general NHA
  - With the aim of institutionalization
  - As a stand-alone exercise
- Understand the major tasks involved in completing a subaccounts from start to finish

Content

- Slide presentation
- Exercises
- Answers

Exercises

- Questions
- Exercises

Unit 7 - Slide Presentations

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Unit 7: Implementation Process for Reproductive Health Subaccounts

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2

Learning objectives

- Recognize what is entailed in conducting the subaccount estimation
  - Concurrently with general NHA
  - With the aim of institutionalization
  - As a stand-alone exercise
- Understand the major tasks involved in completing a subaccounts from start to finish

3

Ideal Approach

- Conduct subaccounts
  - **As part of ongoing general NHA effort**
    - Allows for placing reproductive health in context of overall health expenditures
      - Important for policy purposes, because RH competes with other health needs
    - Cost-effective to piggy-back onto ongoing NHA surveys.
  - **With the goal of institutionalization**
    - If done every other year, allows for trend analysis
  - **This will be described in the following slides**

4

Some Key Features of Institutionalization

- Recurrence – trend data important
- Policy use – needs to be used for health policy, not merely as a research exercise
- Government ownership – should be adopted as a regular government activity, like the census

5

How to plan for institutionalization

- **Incorporate into current estimation round by:**
  - Including "long-term" team members
    - Who can work on future rounds and sustain the momentum after this round is done
  - Identifying weaknesses in HIS (Health Information System) and possible areas for improvement in terms of expenditure info
  - Note regularly occurring studies and negotiate for the addition of RH expenditure rider questions
    - Whether during this round or afterwards
  - Consider how often subaccounts should be conducted and the minimum tables that can be feasibly produced

6

NHA Steering Committee and NHA Team

Make sure to include RH reps on the core team and the SC

7

The technical team: Building demand for the data

- Requires an "NHA advocate"
  - Usually the team leader
  - Who has access to policymakers
  - Job:
    - to generate interest in the RH subaccounts
    - Facilitate formation of the steering committee

8

Team Leader/ advocate; skills and knowledge

- Broad understanding of the health sector
  - Issues and policies
- A deep understanding of NHA and its potential use in the country
- Good contacts throughout the health system
- Excellent management and coordination skills
- A financing background
- A thorough understanding of the target audience
- Strong presentation skills
- Facilitation skills

9

The technical team

- Carry-out actual estimation and write report
  - Entails data collection and analysis
- Recommend multi-sectoral team
  - With representatives from Dept of Planning, Finance, Bureau of statistics, Dept/unit of RH or MCH, etc.
- If interest is to institutionalize, include members from the agency that will continue the work after this round finishes
  - To maintain the momentum, continue to "plug" the findings, keep an eye out for ongoing surveys where NHA rider questions could be added.

10

Role of the technical team

- Undertake inventory and assessment (of usefulness) of existing data for subaccounts
- Identify data gaps and needed primary data collection (design survey instruments, sampling size etc)
- Collect primary and secondary data
- Compile, validate and analyze financial data, and produce NHA tables
- Document methodology
- Prepare report, briefs, presentations of the findings
- Report regularly to the Steering Committee throughout the process.

11

NHA team member: skills and knowledge

- Knowledge of government accounting
- Experience in spreadsheet and word processing (Excel and MS Word)
- Good organization skills
- Familiarity with health data sources
- Research and analytical skills
- Training in NHA methodology, understanding of NHA tables and classifications
- Experience in developing and conducting surveys
- RH Rep- want someone with an in-depth understanding of RH interventions; including prevention, cure and care in the public and private sectors

12

Involving stakeholders

- Potential users of the findings
  - Can identify policy questions
  - Use the findings to inform the policy process
  - e.g. Ministers of Health; managers of programs that are relevant to RH policy; donors and other financing sources; providers for goods, services and IEC for RH; etc
- Input data generators/data sources
  - whose assistance you may need for data retrieval
  - e.g. statistical agencies, government accounting and finance offices, health insurance agencies, Health Information System (HIS) managers

13

Role of Steering Committee

- Meet regularly with technical team
- Help frame policy focus of subaccounts
- Facilitate data retrieval- particularly from "hard to get" data sources
- Provide guidance for the process
- Review the report and help interpret the findings for policy purposes.

14

The Workplan

- The length of time needed depends on
  - Data availability
  - Staff availability
  - Amount of primary data collection (can be time-consuming)
  - Whether or not coordinating with other ongoing studies
  - Targeted number of NHA tables and level of detail needed

15

Key tasks of the workplan

- Hold launch conference for steering committee
  - Identify policy objectives of NHA
- Hold NHA team training workshop on methodology
  - Agree on classifications and boundaries
  - Develop NHA framework and approach
  - Identify primary and secondary data sources
  - Develop data plan as stated in earlier presentation

16

Key Tasks of workplan cont'd

- Develop survey instruments
- Determine sampling framework and number of enumerators
- Pilot test and finalize survey instruments
- Draw clear procedures for data collection and entry
- Implement data collection
  - Requires a lot of follow-up!!!

17

Key Tasks of workplan cont'd

- Edit and entry data
- Clean data
  - Do not underestimate this process!
- Prepare for data analysis workshop
  - Collect non-expenditure data- e.g. currency rates, weighting plans, population size etc.
- Conduct data analysis workshop and populate the matrices
- KEEP SC INFORMED THROUGHOUT NHA PROCESS
- Draft report
- Disseminate draft NHA report for SC approval
- Finalize report and policy briefs

18

When RH subaccounts is done as a stand alone study

- Pros:
  - Allows for estimation of "non-health" expenditures as is essentially a "RH ACCOUNTS" – however with standard ICHA codes
  - Can include spending on indirect activities
  - Does not need to involve too many stakeholders; this can cut down on time

19

When RH subaccounts is done as a stand alone study cont'd

- Cons:
  - **May be difficult to estimate non-targeted health expenditures**
    - Non-targeted RH expenditures are usually estimated by applying an allocation factor to overall health expenditures of a facility (usually captured in general NHA)
  - **More costly**
  - **May not be effective as a monitoring tool because of the lack of the general NHA reference**
    - Hard to institutionalize; more of a STUDY
  - **Difficult to do cross-country comparisons**

20

Take home message

- Recommend implementing subaccounts as part of the general NHA process
- The more stakeholders involved, the greater the likelihood of use in the policy process
- If institutionalized, can provide valuable trend data

21

Discussion questions

- **What are the policy issues in your country that a RH subaccounts can address?**
- **How do you foresee the process of implementation in your own country?**
  - How easy or difficult will it be? Is this exercise justified?
    - What will be the major challenges?
  - When do you think your country can implement the subaccounts?
  - What will be your next steps in terms of getting RH subaccounts on 'agenda'?
  - What are the expected uses of the RH subaccounts?
- **Each country should prepare to prepare a 5-minute oral presentation on this topic**

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Thank you

Reports related to this presentation are available at www.healthsystems2020.org and www.africahealth2010.aed.org

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HEALTH SYSTEMS 2020

Unit 7 - Exercises

Discussion Question 1

How do you foresee the process of implementation in your own country?

Discussion Question 1a

How easy or difficult will it be?

Answer

Discussion Question 1b

What will be the major challenges?

Answer

Discussion Question 1c

When do you think your country can implement the subaccounts?

Answer

Discussion Question 1d

What will be your next steps in terms of getting the reproductive health subaccounts on the "agenda"?

Unit 7 - Answers

Discussion Question 1

How do you foresee the process of implementation in your own country?

Discussion Question 1a

How easy or difficult will it be?

Answer

Discussion Question 1b

What will be the major challenges?

Answer

Discussion Question 1c

When do you think your country can implement the subaccounts?

Answer

Discussion Question 1d

What will be your next steps in terms of getting the reproductive health subaccounts on the "agenda"?

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