National Health Accounts:

NHA

Regional Policy Brief

Many countries in Eastern, Central, and Southern Africa (ECSA) are in the process of reforming their health systems in an effort to improve the efficiency and management of health services, and to improve the distribution of these services particularly among the poor.

With health systems growing both in scope and complexity, policymakers need tools to help them better manage their health care resources. National Health Accounts (NHA) is one such tool that helps countries to visualize clearly the flow of funds through the health system so as to contribute to "better informed" policy decisions.

Eastern, Central, and Southern Africa:

Using NHA to Inform the Policy Process

What is National Health Accounts?

NHA is a framework for measuring total – public, private, and donor – national health expenditures. Formatted in a standard set of tables, NHA methodology organizes, tabulates, and presents health-spending information in a user-friendly format. This format can be easily understood and interpreted by policymakers – including those without a background in economics. NHA essentially measures the "financial pulse" of national health systems, by answering questions like:

- Who in the country is financing health services? How much do they spend?
- On what types of services?
- How are funds distributed across different services, interventions, and activities?
- Who benefits from these health expenditures?

Why is NHA relevant to policy-making?

NHA is designed specifically to assist policymakers understand their health systems and to improve system performance. NHA information is useful to the decision-making process because it assesses current use of financial resources, tracks health expenditure trends over time, and allows comparison of the country's health system performance relative to other countries. NHA methodology can also be used to make financial projections of a country's health systems needs. Likewise, NHA can highlight equity imbalances among distribution of health expenditures. Essentially NHA helps policymakers make better-informed decisions.

The Eastern, Central, and Southern Africa NHA Network

Ten African countries completed their first round of NHA in 2000: Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. These countries embarked upon their first round of NHA in a collaborative manner that involved the formation of the Eastern, Central, and Southern African (ECSA) NHA network. The network was composed of country teams made up of representatives from governmental, non-governmental, and research institutions. Over the course of a year and a half, network members participated in NHA training seminars and policymaker dissemination conferences and developed a regional comparative NHA findings report. Training workshops and other regional meetings of the network allowed for cross-country sharing of experiences and lessons learned and for country teams to work together to find solutions to common problems faced in NHA implementation.

Since 2000, the ECSA network has added member countries and it continues to grow. The countries have made great strides toward generating political committment for NHA, as evidenced recently by a Ministers of Health conference where participants unanimously agreed to intitutionalize NHA in their country and to adopt a common institutionalization framework. The network is now coordinated by a local regional organization, the Commonwealth for Regional Health Community Secretariat (CRHCS), based in Arusha, Tanzania. Working in collaboration with CRHCS is the U.S. Agency for International Development/Regional Economic Development Services Office-sponsored Partners for Health Reform*plus* project (PHR*plus*) that primarily contributes technical assistance to the network. Numerous donor partners provide assistance in financing the participation of country teams at regional events. These donors include the World Health Organization/Africa Regional Office (WHO/AFRO), the Swedish International Development Cooperation Agency (Sida), and the European Commission (EC). This list of donor partners is growing and plans are being developed with the increased support of WHO/AFRO to expand the ECSA network to become an Anglophone African NHA network. Also envisioned is the greater participation and leadership of local NHA experts, particularly in the delivery of training workshops.

How has NHA informed the policy process in Eastern, Central, and Southern Africa?

Resource distribution in South Africa: Soon after the end of apartheid in South Africa, one of the government's major policy objectives was to achieve a more equitable distribution of health resources. The government tailored NHA to meet this policy objective to show how health funds were used and by whom.

South Africa's NHA analysis revealed that less money was being invested in government health services delivered in poorer magisterial districts compared with wealthier districts. Average public health expenditure per person was 3.6 times higher in the richest districts than in the poorest districts. Also, the poorer districts – which tended to be areas facing the greatest health problems – had the worst geographical access to health workers, hospitals, and clinics. Specifically, the richest magisterial districts employed 4.5 as many doctors and 2.4 as many registered nurses than did the poorest ones.

These NHA findings served as an impetus to design new policies to geographically redistribute South Africa's health resources in a more equitable manner. For example, the government enacted a moratorium on the construction of new private hospitals in an effort to achieve equity in health infrastructure. Previously, hospitals were usually built in the richer neighborhoods that already had the greatest access to health care. This moratorium illustrated the government's desire to take a more active role in coordinating and regulating where both public and private resources are used to better meet the populations' health needs. The equity issues highlighted by the NHA study also contributed to the government committing to shift public health funds to primary care services and infrastructure, particularly in poor and rural regions of the country.

Distribution of Selected Health Care Resources by Income Quintile and Province in South Africa 1992/93

Income Quintiles of Magisterial Districts	General Doctors (per 100,000 pop.)	Registered Nurses (per 100,000 pop.)
I (lowest)	5.1	78.8
II	9.4	90.9
III	15.8	128.4
IV	13.5	128.2
V (highest)	23.3	189.9
National Avg.	14.1	129.5

Source: McIntyre, D. et al. 1995. *Health Expenditure and Finance in South Africa.* Health Systems Trust and the World Bank, South Africa.

Province (ranked according to personal disposable income, lowest to highest)	Total Health Expenditure per Capita (Rand)
Northern Province	164.07
Eastern Cape	226.98
North-West Territory	178.91
KwaZulu-Natal	236.88
Mpumalanga	136.60
Free State	266.49
Northern Cape	221.15
Western Cape	491.13
Gauteng	381.66
National Avg.	262.61

Source: Bureau of Market Research. 2002. *The South African Provinces: Population and Economic Welfare Levels, 2000*. UNISA. http://www.unisa.ac.za/dept/brm/

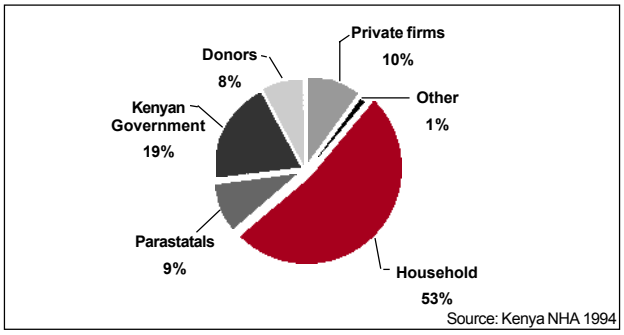
In South Africa, NHA significantly contributed to the development of policies aiming to improve equity by providing information on the extent to which each income level and province absorbed country health care resources.

Influencing government policy in Kenya:[1] Kenya conducted its first NHA in 1998, using 1994 data. Prior to health accounts, the perception among key policymakers was that the government was the major financier of health care

[1] Contributed by Steven Muchiri, Deputy Director for the Department of Planning, Ministry of Health, Kenya, and current NHA team leader.

services. However, NHA revealed that more than 53 percent of health care spending actually came from households, with the Kenyan government financing only 19 percent. The high household expenditure was particularly alarming as 56 percent of the polulation lived below the poverty line. Surprised government officials at first distrusted these findings that so dramatically differed from their perceptions, but they gradually came to understand and accept the results, especially as NHA has revealed similar proportions of government and household expenditures in neighboring countries.

Health Expenditures by Financing Source in Kenya, 1994



NHA results indicating the high household share of health spending served as an advocacy tool that contributed to the government's decision to examine equity issues and better track private health expenditures.

In fact, the findings served as a catalyst for Kenyan policymakers to examine health care equity issues. Consequently, they are commissioning a series of in-depth studies on the burden of health financing in the country. For example, to obtain more credible and methodologically sound data, the country is implementing a health spending-specific household survey for the second round of NHA. (Household expenditures used in the first NHA were derived from the country's Welfare Monitoring Survey of 1994.) Also, the first NHA report has prompted the government to track public health expenditures in an effort to assess how truly pro-poor they are; this is being done under the Public Expenditure Review initiative.

Why conduct NHA in the ECSA region?

Health sector reform initiatives in ECSA countries are based on an underlying principle of equity – that resources be distributed efficiently and fairly. As governments strive to orient policy towards the design of more equitable health systems, the collection and use of NHA data becomes even more important. The flexibility of the NHA framework also allows for the collection and analysis of data indicators targeted at specific populations or disease-specific activities.

The heavy burden of HIV/AIDS and other infectious diseases like malaria and tuberculosis adds to the challenges faced by the health systems in the ECSA region. Throughout the region, HIV prevalence among 15-49 year olds is as high as 10 percent, and, in countries further to the south, the prevalence rate among this age group is higher than 20 percent. As shown by the Rwandan experience below, NHA can provide policymakers with critical data that can be used in designing policy to address not only HIV/AIDS, but also other health problems that affect their country.

HIV/AIDS in Rwanda: Rwanda began its NHA activity in 1999 and extended the framework to include NHA analysis specifically of HIV/AIDS-related expenditures. The findings enabled the Ministry of Health to design and implement targeted policy interventions aimed at improving the financing of prevention activities and increasing access to basic health care services for people living with HIV/AIDS. Given the severity of the disease's impact on the population, understanding the sources of financing available and how funds are used was key to designing effective interventions for dealing with the pandemic.

The results of the NHA analysis on HIV/AIDS expenditures showed that households were the primary source of financing for health care costs related to HIV/AIDS. Indeed, 93.5 percent of all expenditures related to HIV/AIDS came from households. This high proportional contribution to AIDS health care costs amounts to 29 percent of total household spending on health, revealing the great financial impact of the disease.[2] The combined findings from NHA analyses exposed a number of weaknesses in the equity and efficiency of HIV/AIDS funding, all of which challenge

[2] Barnett C., M. Bhawalkar, A.K. Nandakumar, and P. Schneider. February 2001. The application of the National Health Accounts Framework to HIV/AIDS in Rwanda. Special Initiatives Report No. 31, Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

policymakers to more adequately address the flow of HIV/AIDS expenditures. For example, only 10 percent of all health monies were used to target prevention and treatment of the HIV virus in 1999, in the face of an illness that affects 11.2 percent of the adult population – approximately 370,000 people.

In response to the findings from NHA analysis conducted on HIV/AIDS expenditures in Rwanda, the NHA HIV/AIDS data tables were incorporated into the National Development Indicators book. This step to institutionalize NHA in Rwanda will foster the continued contribution of this tool for policy, by providing an ongoing source of information for increasing the effectiveness of targeted health programs. In addition, NHA results revealed donor funds for HIV/AIDS programs were lacking, prompting the donor community to increase HIV/AIDS-specific contributions from U.S. $0.5 million in 1998 to more than U.S. $1.6 million in 2000.

What does it take to implement NHA?

The key ingredients for a country's success with NHA are political will and the commitment of senior decision makers. Their support provides the impetus for initial adoption of NHA in their country, and their concrete actions, such as allocating personnel and financial resources for the NHA activity, provide for implementation on a sustainable basis. Institutionalization of NHA is ideal; of the 68 countries around the world that have conducted health accounts, approximately one-third do so on a regular, sustained basis.

Also integral to the success of NHA is ongoing communication between policymakers and the NHA team. This interaction is crucial so that the policy tool is used to address specific policy concerns and do subsector analyses. NHA technical teams should represent the entire national health system – they should include members from the private and public sector as well as parastatal organizations. Members should bring skills that allow the team to collect data, define expenditure boundaries, analyze the data, interpret the results for policymakers, and focus the dissemination strategy for NHA results. Staunch support from policymakers is needed to create a legal infrastructure that allows the NHA team to collect data from various entities on an annual basis, to integrate NHA into the country's System of National Accounts and produce NHA as part of the annual national accounts, and, ultimately, to consistently use the data NHA produces to implement meaningful and effective reforms in the health system. Over the years, NHA data will also allow for trend analyses and monitoring of the impact of various interventions.

So that NHA can be relied upon for good national policy decisions, countries that use the methodology must ensure that the data fed into it are as complete, accurate, and consistent as possible. To make cross-country comparisons, data must also conform to international standards and definitions. This implies financial transparency among agencies, both public and private, and investment in the development of data tracking and reporting systems, accounting systems, and associated activities, such as household surveys. A broad range of policymakers must be made more aware of NHA findings and especially their relevance to policy formulation. Only as NHA can prove its usefulness will it continue to gain adherents.

This *Brief* was compiled by Margaret Maier. The final editing and review was conducted by Susna De and A.K. Nandakumar. Michelle Munro served as graphic designer.

PHR*plus*

Abt Associates Inc.
4800 Montgomery Lane
Suite 600
Bethesda, MD 20814 USA
Tel: 301-913-0500
Fax: 301-652-3916
URL: www.PHRplus.org
E-mail:
PHR-InfoCenter@abtassoc.com

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