National Health Accounts:

NHA

Regional Policy Brief

As health systems have grown and become more complex,[1] planners and policymakers need tools to analyze health financing. These tools can help them better understand their own system and make comparisons with the experiences of other nations. National Health Accounts (NHA) is one such tool being used today in more than 68 countries worldwide, including at least half of all countries belonging to the Organization for Economic Cooperation and Development (OECD).

[1] Global health expenditures have risen from an estimated 3% of world product in 1948 to almost 8% in 1997. (World Health Organization. 2000. *World Health Report*. Geneva.)

Europe and Central Asia:

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. NHA methodology helps countries to clearly visualize the flow of funds through the health sector, from their sources, through financial intermediaries, to providers and functions. In short, health accounts answer three basic questions: Who is financing health care in a particular country? How much do they spend? And on what types of services? This globally accepted tool essentially highlights the "financial pulse" of national health systems.

NHA is a standard set of matrices, or tables, that presents various aspects of a nation's health expenditures. The expenditure review approach takes place independent of the structure of a country's health finance system, making it an attractive policy tool. NHA can include:

- A rigorous classification of the types and purposes of expenditures and of the actors in the health system;
- A complete accounting of all spending for health, regardless of the origin, destination, or object of the expenditure;
- A rigorous approach to collecting, cataloging, and estimating those flows of money; and
- A structure intended for ongoing analysis as opposed to one-time study.

Why is NHA relevant to policymaking?

NHA is designed specifically as a policy tool for improving the capacity of health sector planners to manage their health systems. The NHA methodology organizes, tabulates, and presents health spending information in a standard format, one that can be easily understood and interpreted by all policymakers, including those without a background in economics.

This allows decision makers to understand how health resources are used in a health care system, to review allocation patterns, to assess the efficiency of current resource use, and to evaluate impact of health care reform. It also allows for comparisons of a health system at different points in time, and comparisons of one country's health system with others. NHA may also provide new information to decision makers. For example, they may be surprised to discover the extent of private out-of-pocket expenditures even when publicly provided free health services are available. Such information allows policymakers to better tailor policies to meet the needs of their population.

How has NHA informed the policy process?

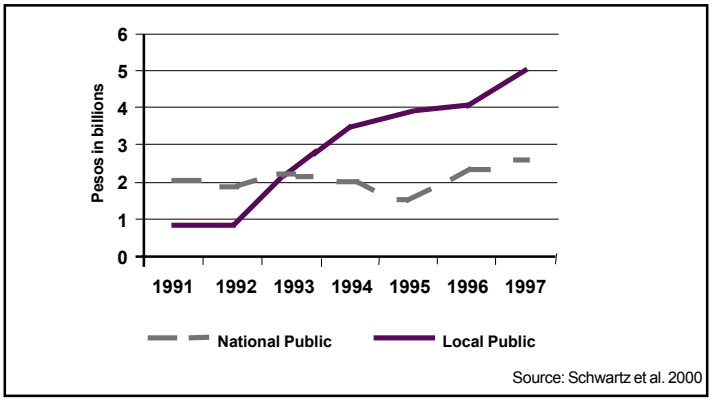
Despite being introduced only recently to most middle- and low-income countries, NHA findings have already begun to affect the health sector policies of many countries. Broadly

speaking, NHA has been used to monitor and evaluate health care interventions, contribute to policy design and implementation, and inform health policy dialogue.

Monitoring and evaluation: In countries where NHA is carried out periodically, intertemporal comparisons help to evaluate if implemented strategies have had their expected impact. In the Philippines, NHA studies conducted on an annual basis from 1991 to 1997 coupled with other data were used to evaluate the results of the 1993 decentralization policy. In particular, NHA was used to assess the *allocative* efficiency changes in local government health spending.

Findings showed that from the onset of the decentralization process, local governments sizably increased their financial contribution to health care from their increased budget allocations from the central government. These results suggested that local governments were committed to health expenditures. Prior to the reforms, both central and regional funding was very low, and, in the case of the central government, funding was actually decreasing significantly. NHAs found that, after the reforms, spending on "public" health care services (such as immunization, which benefit the community at large as well as the individual) actually increased from 25 percent to 35 percent of government health spending. This increase was largely due to increased funding from local governments, which in 1997 allocated more than half of their health resources to public health care. Thus, NHA and, in particular, its implementation on an annual basis (trend data) provided significant insight into the impact of decentralization on health care.

Philippines National and Local Government Expenditures on Public Health Care (at constant 1991 prices)



Source: Schwartz et al. 2000

NHA showed that the implementation of the decentralization process allowed for increased financial commitment of local governments to health care.

Policy design and implementation: NHA results have also been used in the formulation of specific strategies. 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. Thus, NHA was tailored to meet this policy objective and it revealed how health funds were used and by whom. The study found that less money was invested in government health services delivered in the poorer magisterial districts than in the wealthier ones. Average public health expenditure per person was 3.6 times more in the richest districts compared to the poorest districts. Also, the poorer districts (which are areas with the greatest health problems) had the worst geographical access to health workers, hospitals, and clinics. Specifically, the richest magisterial districts employed 4.5 times more doctors and 2.4 times more registered nurses than did the poorest areas.

Distribution of Resources in South Africa

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 et al. 1995

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: McIntyre et al. 1995, Bureau of Market Research 2000

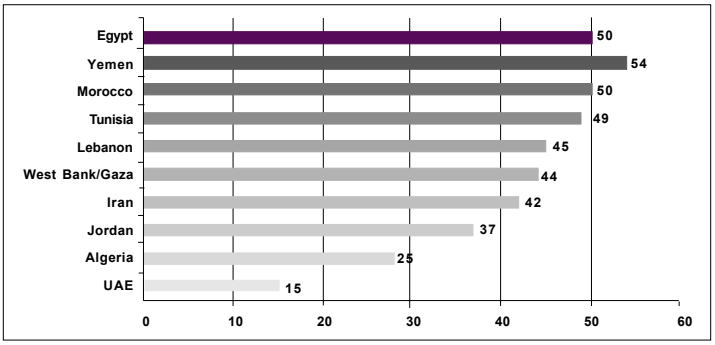
In South Africa, NHA contributed significantly to the development of policies to improve equity by providing information on the extent to which each income level and province absorbed health care resources.

In addition to contributing to increased awareness at the senior policy level regarding the disparities in resource allocation, NHA findings served as an impetus for designing new policies to geographically redistribute South Africa's health resources in a more equitable manner than was done in the past. For example, a government moratorium was placed on the building of private hospitals, because these hospitals usually had been built in the richest neighborhoods, which already had the greatest access to health care. The moratorium was lifted only after policymakers developed regulations requiring an assessment of need before construction of a hospital is permitted. This moratorium illustrates the government's desire to take a more active role in coordinating and regulating where both public and private health resources are used. The *equity*

issues highlighted by the study also contributed to the government committing to shift public health funds to primary health care services and infrastructure, particularly in poor and rural regions of the country.

Policy dialogue: At the dialogue stage, NHA results have been used: (1) to identify problems; (2) to serve as a catalyst for change by attaching data that convey the magnitude of a problem; and (3) to act as an advocacy instrument to stimulate action. In Egypt, NHA findings, combined with non-financial data, were used by the Minister of Health and international agencies (World Bank, USAID, and European Commission) to initiate a policy dialogue that led to the design and ongoing implementation of a primary health care restructuring initiative.

Household Out-of-Pocket Expenditures as % of Total for Selected Middle East and North African Countries



Source: Based on Rafeh and Maeda 1997

NHA revealed that, despite the presence of a significant government health care infrastructure, Egypt ranked among the top three Middle East and North African countries with respect to household out-of-pocket expenditures on private health care.

NHA contributed to the promotion of this initiative when it showed that Egypt spent nearly 4 percent of its GDP on health care, with household out-of-pocket expenditures amounting to 50 percent of total expenditures, and the Ministry of Health and Population accounting for less than 20 percent of total expenditures. While the sum spent on primary care should have been adequate to provide a set of basic services to all the population, the funding was not organized or allocated efficiently. The burden of these expenditures was very inequitably distributed, with the poor paying the largest share of income. This form of financing also resulted in lower levels of access by the poor and those living in rural areas.

Such findings provided the Minister of Health and Population with the information needed to convince the Peoples Assembly, the public, and those working within the ministry of the value of the reform agenda as well as financing support. The main element of this reform agenda was a basic package of primary health care benefits that would be provided to all Egyptians. Contributions from a number of governmental agencies would be pooled in a fund that, along with modest co-payments, would finance these services. The reform strategies were then pilot tested. Based upon favorable results from the pilot sites, plans are presently being drawn up to expand reforms to other areas.

Why conduct NHA in Europe and Central Asia?

Since the early 1990s, countries in the Europe and Central Asia (ECA) region have been transitioning from central planning and state controlled management to decentralized, market driven economies. Reforms that increase transparency and accountability at all levels of government are vital components in the decentralization process. NHA can contribute to improving transparency in the ECA health systems by informing policymakers of the financial allocation of health funds. Such information would also help decision makers to make sound policy decisions and avert potentially bad ones. As illustrated above, NHA can inform numerous policy areas including the monitoring of decentralization strategies, the mobilization of resources for health care, the containment of health care costs, and the maximization of efficiency and effectiveness of the health sector.

In addition to fulfilling internal country needs for health expenditure information, NHA helps link countries to the global community. The European Union (EU) recognizes the importance of health accounts and strongly urges countries wishing to join the EU to first implement and institutionalize sound health information systems. NHA is one system that the EU promotes. The OECD also has championed the measurement of health expenditures among its member countries since the 1970s.

The flexibility and expansibility of NHA's framework and structure also allow for the collection and analysis of data indicators targeted at specific populations or disease-specific activities. This could be particularly useful in the ECA region should policymakers wish to measure expenditures relating to specific disease burdens such as HIV/AIDS and tuberculosis, both of which have grown at alarming rates in the region. In Rwanda, where HIV/AIDS is a sizeable disease burden, disease-specific sub-analysis revealed that a disproportionate share (93.5 percent) of expenditures for HIV/AIDS services was financed by

households, while governments and donors contributed to only 7 percent. Other examples of NHA sub-analyses that countries have conducted are the monitoring of spending patterns of maternal and child health care, reproductive health services, and sub-national (provincial or district) health sectors.

What is needed to implement NHA?

Key to successful implementation of NHA are the political and financial commitment of senior decision makers. Their recognition of NHA's value for policymaking must manifest itself in concrete action, such as sustainable allocation of personnel and financial resources for the NHA activity.

Policymaker support is also needed so that the NHA technical team can collect data on annually from government agencies, public and private providers, and other entities. This calls for creation of a legal infrastructure that allows for, indeed requires, data sharing.

So that NHA can be relied on for good national policy decisions as well as for cross-country comparisons, the data used to do a country's NHA must be as complete, accurate, and consistent as possible. They must also conform to international standards and definitions. This demands financial transparency among agencies, both public and private, and development of data tracking and reporting systems, accounting systems, and associated activities such as household surveys.

Also critical to the success of NHA is ongoing communication between policymakers and the NHA technical team. This interaction allows the policy tool to be molded to address specific policy concerns and do additional sub-analyses.

NHA technical teams should represent the entire national health sector – public and private sectors and parastatal organizations – and members should possess a range of skills. Their tasks include collecting and analyzing data, defining expenditure boundaries, interpreting findings in a way that is relevant to policymaking, and presenting the information in a way that is understandable to policymakers. As policymakers become increasingly aware of NHA's utility, the tool will gain their support.

The sign of NHA's ultimate success is its integration into a country's System of National Accounts and its production as part of the annual national accounts package, and when the data it produces is used to implement meaningful health sector reforms and then to monitor the impact of those interventions. Over the years, the data also will be used for trend analyses.

To date, about one-third of the countries that have conducted NHA have institutionalized the tool and repeat it on a regular, sustained basis.

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