

National Health Accounts

What Are They and How Can We Use Them?

Briefing Paper

A paper produced by the Department for International Development Resource Centre for Health Sector Reform

1. Introduction

A better understanding of the ways in which health services are financed is a major element in understanding why the available resources are not translated into better health outcomes and in identifying measures which can improve this.

When considering issues of health financing a number of key questions arise:

- what is total spending on health?
- who is spending it? (poor/rich? rural/urban? north/south?)
- what is it being spent on? (PHC? hospitals? MoH HQ?)
- what are the sources of this expenditure? (Government? donors? NGOs? private?)
- how does this compare to other countries in the region?
- what are the main trends?
- how efficiently are the funds being allocated and spent?
- what can we do to improve the financing of health services by:
 - increasing the level of resources available?
 - using and allocating existing resources more efficiently?
- are public subsidies being effectively targeted to poor and vulnerable groups?

This paper sets out the extent to which a National Health Accounts approach can begin to address some of these questions, some of the limitations associated with the approach and other relevant issues.

2. What Are National Health Accounts?

National Health Accounts offer a **systematic approach** to mapping the flow of health sector funds around (and sometimes leaking out of) the health system over a defined period of time. The process involves bringing together data from a variety of sources. In some cases routine data may be available, in others the data will come from surveys commissioned for other purposes e.g. data on private health expenditure often comes from national household surveys. National Health Accounts involves the analysis and compilation of the available data, the commissioning of work to fill any gaps and the compilation and presentation of this data in a user friendly form.

What Do They Look Like? - An Example – The Case of India

National Health Spending: An Estimated “Source and Uses” Matrix

Sources (% of total expenditure)					
Uses	Central Govt	State and Local Govt	Corporate/ 3 rd Party	Households	Total
Primary Care	4.3	5.6	0.8	48.0	58.7
• Curative	0.4	3.0	0.8	45.6	49.7
• Preventive and promotive health	4.0	2.7	0.0	2.4	9.0
Secondary/tertiary In Patient care	0.9	8.4	2.5	27.0	38.8
Non Service Provision	0.9	1.6	N/A	N/A	2.5
Total	6.1	15.6	3.3	75.0	100.0

Derived from: India: Policy and Finance Strategies for Strengthening PHC: World Bank 1995

The methodology is developing and reasonably consistent approaches have been used in OECD countries which has allowed cross country comparisons to be made. In developing countries the approach has been far less systematic. In some NHA have been carried out in others the available data on key financing issues is either virtually non existent or has not been properly compiled.

A Partnership for Health Reform Special Initiative (www.phrproject.com) is supporting USAID’s Population, Health and Nutrition in this area by developing standard tools and software and capacity building (in part through the development of regional networks). The overall aim is to promote both consistency of scope and broader coverage for NHA within developing countries.

3. What Are The Benefits?

Key Benefits

Health financing data provides a **vital input to the planning process** and the establishment of overall resource envelopes (a key element of a SWAp approach). The provision of the right data at the right time can have a **significant impact on policy** e.g. resource reallocations, recognition of need to focus on regulation of the private sector. The **process** of carrying out NHA can **promote policy dialogue** on key policy issues. Where data is consistent between countries it facilitates international comparisons which can be used to assess the impact of health sector reforms. The approach can improve **transparency** - e.g. it can give a clearer picture of the split between recurrent and capital expenditure and give a better idea of donor dependency. It allows health reforms and elements of overall health sector performance to be tracked insofar as they relate to financing changes. It allows the MoH to provide a stronger case to the MoF for changes in the budgetary process by “speaking in a language they understand”. It facilitates **triangulation** – the cross checking of findings from other sources Finally, it gives a big picture view of the sources and uses of all health expenditure including public-private mix both on the financing side and on the provision side.

The benefits tend to be greatest where:

- the current data base is extremely weak and that the results can tell you things you didn't know or suspect – **dispelling myths**. For example, in Bangladesh the role of the NGO sector was found to be far smaller than expected. In many cases a typical finding is that private financing is far higher than previously anticipated and the realisation within Ministries of Health that they spend 95% of their time looking at 20% of total expenditure!
- financing sources are extremely diverse and systems complex e.g. multiple donors financial intermediaries, large number of NGOs
- current budget systems are not transparent
- systems are extremely decentralised
- significant reforms have been implemented

4. What Are The Limitations?

- NHA cannot answer all of the key questions outlined as shown in the table below. (This relates to current practice rather than the agreed methodology)

Question	Does NHA Address This Issue?
what is total spending on health?	Yes
who is spending it?	Yes
what is it being spent on?	Yes
what are the sources of this expenditure?	Yes
how does this compare to other countries in the region?	Yes, (emphasis is usually on international rather than regional)
what are the main trends?	Yes, (if process is institutionalised)
how efficiently are the funds being allocated and spent?	No
what can we do to improve the financing of health services by <ul style="list-style-type: none"> • Increasing the level of resources available? • using and allocating existing resources more efficiently? 	No
are public subsidies being effectively targeted to poor and vulnerable groups?	Generally No

- It focuses generally on the level of spend, sources and uses. It does not directly address the issue of allocative efficiency beyond actually demonstrating how resources are allocated. It says nothing at all about technical efficiency. On the one hand, therefore, it could be argued that NHA raise more questions than they answer. On the other, NHA provides a set of core information which raises further issues which have to be addressed through other means. In the case of Bangladesh, for example, it was not possible to break down expenditure by district; in Bosnia &

Herzegovina it was and this revealed large discrepancies in expenditure between the Federation (with average spending at \$77 per head) and the republic of Srpska (\$22).

- the impact of NHA on policy may be overestimated to the extent that it results may be used mainly for the validation of existing policies. Results may be ignored where not palatable and used only when they support existing policies.
- access to quality data is often extremely difficult. It is much easier to get figures on budgets and commitments than actual disbursements. Donors are often unwilling or unable to provide the necessary data. The private sector may be unwilling to part with data for fear it will be used against them e.g. for tax purposes
- the approach uses a financial rather than an economic approach to costs. The figures included in NHA, therefore, relate to what people or institutions actually pay and not necessarily what it costs them. It does not, for example, include the costs associated with time taken off work to access health services.
- it can also be argued by sceptics that commissioning National Health Accounts can also be used as a means of delaying important decisions.

It should also be noted that DfID advisers will rarely, if ever, be able to provide Ministries with the degree of information necessary to complete National Health Accounts i.e. DFID spend in the Government's last Financial Year broken down by district or region, by use (hospital, PHC, community based), by type of input (commodities, salaries, other running costs, TA, capital development etc?).

A detailed coverage of methodological problems can be found in the literature and is not covered here.

5. Issues and Concerns

Interpretation

Ministries of Health and some donors put too much emphasis on overall spending levels and too little on what it is being spent on. In particular, there is much pressure to achieve the \$12 required to provide the minimum package (WDR, 1993) when in many countries such levels of support are not sustainable and such funds could not be absorbed and used effectively. Where a country has developed a basic essential or minimum package it may be useful to estimate the proportion of public spending currently devoted to this area. (This is not typically carried out and the figure will often be very low!).

There is also a danger in interpreting static one off NHA analyses. Uganda, for example, spends far more on health than Kenya and Tanzania yet has worse health indicators. However, this is due less to current poor performance and more to past neglect. Results should be carefully interpreted in the light of all available information and decisions about attribution not made lightly.

Standard Blueprint vs Local Relevance

Much international effort has been expended on developing consistent approaches. This conflicts at times with the requirement to provide data in a form most accessible to health managers and relevant to their needs. Different countries, for example, will require different degrees of disaggregation.

Value for Money

The exercise is not cost free. Although it has benefits (greater in some situations than others) these have to be weighed against costs which may be high. (Some examples of costs) In addition, one should consider whether such activities represent the best use of available skills in countries where capacity is very limited. Staff will usually welcome the opportunity to participate in such work – the question is whether it is the best use of their time. An ad hoc response for NHA type data as the need arises may be more appropriate in some circumstances.

Commitment

The approach needs a high degree of political support from the top. It requires the good will of many stakeholders to provide the necessary data; it also requires a willingness to accept unpalatable results

To Institutionalise the Process or a One Off Exercise?

A number of choices exist here. There are certain core areas where it is important that the data should be collected regularly and it is preferable that such activity should be institutionalised. The other role of NHA is in monitoring overall reforms. Thus, it may make sense for the initial NHA to be more in depth and for such an analysis to be repeated for example every 5 years. In this case it would be advisable to build local capacity to oversee and monitor such activities without necessarily having the in house capacity to actually carry it out. Initial NHAs might identify core activities and outline measures to improve capacity

Specific Health Approaches or Piggy Backing?

It often makes sense to add additional questions to ongoing household surveys. In some cases cost considerations and limits to the number of questions which can be asked renders the value of the results rather meaningless.

6. Conclusions

NHA are not a panacea. They are a starting point which may identify key areas for further work. They will rarely, for example, show whether the funds are being utilised by poorer groups in line with DfID's mission (although the Bangladesh NHA is a notable example see annex 2). They may also be used for triangulation – to confirm or support findings from other sources.

NHA should be aimed primarily at meeting domestic needs. If this is consistent with the international methodology and can use the tools developed then fine; if not the approach still needs to be methodologically sound but should meet local requirements.

NHA can be a useful entry point for policy dialogue particularly in relation to issues such as resource envelopes and prioritisation of scarce resources and sustainability.

Key Documents and Further Reading

- ◆ National Health Accounts in Developing Countries: Appropriate Methods and Recent Applications Peter Berman Health Economics vol. 6: 11-30 (1997)
- ◆ Report on IHSD Conference April 1999 and presentations by Jane Haycock (General and Bosnia & Herzegovina), Mark Pearson (Uganda) and Simon Shenton Tan (Bangladesh)
- ◆ User's Manual: National Health Accounts
PHR Special Initiative Report 2 | Order No. SIR 2
- ◆ Bangladesh National Health Accounts – Health Economics Unit, MoHFW
- ◆ Partnership for Health Reform Website : <http://www.phrproject.com>

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