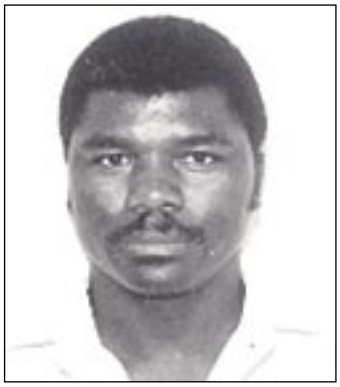
National health accounts: the Namibian experience



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Background

National Health Accounts (NHAs) are vital tools for diagnosing the financial functions of health systems and designing sound health financing policies. They should lead to an improvement in the performance of health systems and, ultimately, to an improvement in the health status of the population.

Namibia, with a surface area of 824 116 square kilometers, is located in the southwestern part of the African continent. The country has a population of 1.8 million and a population density of 2.1 persons per square kilometre. With a per capita income of US$ 1,980, the country is classified as a middle-income country. However, the per capita income masks the reality of a high degree of income inequality.

According to the world health report 2000, the Namibian health system consumed around 7.5% of *Gross Domestic Product,* but the health outcomes in terms of disability adjusted life expectancy were poor compared to other countries at similar levels of development and with similar levels of health expenditure per capita. This scenario has raised questions about the allocative and operational efficiency and equity of the health system.

Policy-makers were concerned that in a country with a legacy of high levels of inequality in health and access to resources, establishing a NHA was of paramount importance to redress ills of the health system inherited from the pre-independence political dispensation. Furthermore, since 2000, the Ministry of Health and Social Services (MoHSS) had, on various occasions, been requested by WHO to provide and validate ratios and per capita levels of national health expenditure as part of its contributions to world health reports. On many occasions, the expenditure figures could not be validated, as no study was done to determine the national health expenditure in the country.

The objective of this article, therefore, is to share the Namibian experience in establishing a national health account.

Situation analysis and training

As a first step, the MoHSS solicited technical support from WHO. In response to the request, WHO sent a mission to Namibia to undertake a situation analysis. WHO also supported the training of three MoHSS staff members on NHAs in Zambia.

The report of the situation analysis helped to map out the flow of funds in the system and evaluate the resource implications of undertaking the study. It also led to the constitution of a multidisciplinary NHA team with members from both within and outside the MoHSS.

Workshops and data collection

The Ministry of Health and Social Services conducted a sensitization workshop for potential stakeholders. The workshop was intended to solicit cooperation and clarify any misconceptions about the nature of the exercise. To underscore the importance of the exercise, the keynote address at the workshop was delivered by the Deputy Minister of Health and Social Services.

Generic questionnaires used by other countries to develop their NHA were

collected by the NHA team and adapted to suit the Namibian situation. Seven types of questionnaires where thus developed, all geared towards collecting information from health insurance companies, donors, nongovernmental organizations, development partners, employers, the MoHSS and other government ministries.

Prior to the data collection process, a second sensitization meeting was held with the aim of introducing the questionnaire to all potential respondents. This meeting was officiated by the Permanent Secretary and Under Secretary (Policy Development and Resource Management) of the MoHSS. The presence of high-level MoHSS officials was meant to underline the importance of the meeting.

For the data collection exercise, 15 field workers were recruited from a pool of experienced survey interviewers; they were given a three-day training session before embarking on fieldwork. The training was very important as it helped the enumerators to understand the questionnaires as well as the terminology used in NHA.

Questionnaires were distributed to the various organizations by enumerators and were collected a week after delivery. E-mail was also used for delivery of questionnaires to some organizations. The data collection and follow-up process lasted for two months.

An Excel spreadsheet with features of the questionnaire was created to allow for data entry. After the data was cleared for consistency, and all follow-ups with the various respondents were done, data were entered into the Excel template.

A weeklong data analysis workshop was organized with the technical support of WHO. The involvement of WHO in all phases of the study also helped to boost the capacity of the NHA team.

Conclusion

The NHA as a tool for policy-makers has had a positive impact on operations in the Ministry of Health and Social Services. Some of the recommendations of the NHA team are already being implemented. These include equalization of per capita regional allocation over a period of time and research to formulate a needs-based resource allocation formula.

The main enabling factor in the finalization of the NHA study was the support the team had received from senior management of the MoHSS as well as all levels of WHO: Country Office, Regional Office and Headquarters.

The constraint in the preparation and finalization of the study was the lack of technical capacity and skills in the MoHSS with regard to health equity analysis as well as lack of hands-on experience in NHA.

As NHA is an essential tool for evaluating on-going health reform strategies, Namibia plans to institutionalize this tool with a view to making it part of its routine Health Management Information System.

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