

The status of National Health Accounts in the African Region

– By Takondwa Mwase

Introduction

A major challenge facing countries in the WHO African Region is ensuring access to essential and high quality health services. This challenge has been brought about by a number of factors, including an increasing disease burden, limited economic resources and growing population. In order to respond to this situation, most countries in the Region are currently at various levels and stages of implementing health sector reforms and, in particular, financial reforms so as to raise additional revenue, and better utilize existing revenue, thus improving the performance of health systems.

Available evidence shows that there has been very little progress made in implementing health sector financing reforms such as user fees, social health insurance and community financing schemes, among others as per capita expenditure on health continues to remain low in the

Region. One of the reasons for this poor performance is the weak stewardship role of governments which, has resulted in lack of vital financial information to guide sound health financing, policy formulation, monitoring and evaluation.

Until recently, no country in the Region had any data on total health spending from all sources, contribution by each source or resource use. Without this information, there is little basis for making informed choices among health care objectives, evaluating alternative ways of financing and allocating resources or developing efficient and effective ways of providing services so as to improve the performance of health systems.

National health accounts

National health accounts (NHA) provide a framework for gathering total actual expenditure on health. The NHA

tracks the flow of funds through the health system from sources of finance, e.g. ministry of finance through financing agents; ministry of health to hospitals or pharmacies. It also depicts spending by function and geographic area.

The NHA mainly responds to the following key questions:

- Who pays and how much is paid for health care?
- Who provides goods and services, and what resources do they use?
- How are health care funds distributed across the different services, interventions and activities that the health system produces?
- Who benefits from health-care expenditure?

By providing answers to these questions, NHA provides information on the adequacy or otherwise of financial resources in the health system; the

Table 1: Flow of funds from sources to financing agents (US\$ millions), 2000

Financing agents	Sources						%
	Ministry of Finance	Local Govt*	Donors	Firms	Households	Total	
Ministry of Health	50		30			80	17.2
Local Government	5	30				35	7.5
Other govt. agencies	30					30	6.5
NGOs	30		70			100	21.5
Health insurance				35	15	50	10.6
Firms				45		45	9.7
Households out-of-pocket					125	125	27.0
Total	115	30	100	80	140	465	100
%	24.7	6.5	21.5	17.2	30.1	100	

nature of financial protection and the fairness of distribution of the financial burden; actual allocation of resources to priority interventions; effectiveness of public subsidies for health; emerging expenditure patterns; benchmarks for health spending; monitoring and evaluation of policy instruments. Table 1 is a matrix showing the flow of funds from the source of expenditure (columns) to financing agents (rows), answering the first question raised above: Who pays and how much do they pay for health? Subsequent tables could be constructed showing financing agents (columns) and providers (rows) and so on.

National health accounts in the African Region

NHA was first introduced in early 1999 in eastern and southern Africa. However, prior to this, efforts had been made by WHO and the World Bank to collect health expenditure data in the Region using Health Expenditure Review and Public Health Expenditure Review frameworks respectively. By the end of 2001, 10 countries had undertaken NHA. In January 2003, the first west African NHA policy-makers sensitization meeting was held in Dakar, Senegal, with participants from 27 countries. This was followed by an NHA technical training course for 12 countries.

Currently, there are 12 countries in the Region officially known to have completed one round of NHA. These are Algeria, Ethiopia, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. Some of these countries, including Ethiopia, Kenya, Malawi, Uganda and Zimbabwe, have embarked on a second round of NHA. The following countries are undertaking their first round of NHA: Gambia, Mauritius, Nigeria, Togo and Swaziland. Preparation for undertaking NHA is currently underway in Benin, Botswana, Burkina Faso, Cape Verde, Chad, Comoros, Ghana, Guinea, Madagascar, Mali, Mozambique, Niger, Senegal, Tanzania and Zambia.

National health accounts results

NHAs have been used in policy dialogue, and debate, design and implementation as well as in monitoring and evaluation in the African Region.

Policy dialogue

NHAs have been used to inform debates, as a catalyst for change by attaching data that convey the magnitude of the problem, and as an advocacy instrument to stimulate action. In Kenya, before the NHA study was undertaken, policy-makers believed that government was the major financier of health services. After an NHA study, it was found that households, through direct out-of-pocket payments, were the major financiers of health services contributing 53% of the total expenditure. The government contributed only 19% of the total expenditure on health.

This finding brought to the fore concern on the decline in relative importance of publicly funded services and reliance on out-of-pocket payment for mainly outpatient services. This questioned government commitment to providing access to primary and preventive health care services. In addition, since user fees tend to dissuade the poor from utilizing health services, it is likely that the majority of the population was being denied access to health services.

As a response, the Kenya Government is now in the process of designing a national social health insurance so as to reduce the huge direct out-of-pocket spending on health and thus encourage utilization of health services.

Policy design and implementation

NHA results are also used for the formulation of specific strategies. In Rwanda, NHA results prompted donors to increase funding for HIV/AIDS. About 11.2% of the adult population in Rwanda is affected by HIV/AIDS. Owing to the magnitude of the disease, the government felt that a clear understanding of the sources of finance and the use of the resources for HIV/AIDS could go

a long way in designing appropriate strategies to tackle the pandemic. To effect this, the Rwanda Government decided to extend their NHA in 1999 which used data from 1998 to include a sub-analysis for HIV/AIDS.

The NHA study revealed that about 51% of total health spending in Rwanda was financed by donors, and the government financed only 9% of the total health spending. The HIV/AIDS sub-analysis revealed that only 10% of total health spending was used for prevention and treatment of HIV/AIDS. The most striking finding was that while donors were the major financiers of health care services in Rwanda, only 1% of the fund accounted for national expenditure on this deadly pandemic. It was also noted that in 1998, households bore the greatest burden of financing HIV/AIDS interventions through direct out-of-pocket spending, at about 93%, while donors and government financed 6% and 1%, respectively. These findings exposed the inconsistency between policy statements on the priority attached to HIV/AIDS and the actual allocation of resources to deal with the pandemic.

Following these findings, donors increased funding for HIV/AIDS interventions from US\$ 0.5 million in 1998 to US\$ 1.6 million by 2000. In addition, the government embarked on piloting pre-paid community schemes so as to improve access to health care services for the population affected by HIV/AIDS.

Monitoring and evaluation

In countries with regular NHAs inter-temporal comparisons help to evaluate if strategies have had their expected impact. In South Africa, the NHA report published in 1995 found that health expenditure was higher than that of other countries at similar levels of development and yet the health status of the population was poor. It was also found that there were serious inequities in health and health care between regions, levels of care and population groups, and inefficiency in resource allocation and utilization. Following these findings, a major restructuring of

the health system commenced in South Africa. The NHA study conducted in 2000 using data for 1997 to 1999 was undertaken so as to monitor and evaluate whether resources had shifted to PHC and between levels of care; whether the health system was sustainable; whether equity had improved; and whether efficiency had improved.

It was found that there were mixed results with regard to equity and efficiency. While there were some improvements in efficiency with regard to increase in resources to PHC, there was also an increase in resources going to the tertiary care level. This was due to changes in the funding mechanism which was no longer based on health needs but "conditional grants" for tertiary hospitals. Discussions are currently underway on developing appropriate funding mechanisms for tertiary care facilities and for funding provinces.

Challenges and perspectives

The major challenges facing NHA development in the Region include limited awareness on the importance of NHA in health policy and planning, inadequate technical capacity and limited financial resources to collect quality data. Thus, in order to overcome these challenges, the WHO Regional Office for Africa in collaboration with partners has agreed to increase awareness of the relevance of NHA to policy-makers and civil society; strengthen technical capacity in the Region; provide technical and financial support to countries to undertake NHA studies; and institutionalize NHA in the Region.

Conclusion

National health accounts are relevant tools for assisting in carrying out the health system function of stewardship

so as to accelerate health sector reform implementation, thereby contributing to improvement of health systems performance. However, countries must ensure that policy-makers are made aware of the importance of this tool and that complete, accurate and consistent data are gathered and analysed for decision-making. It also requires transparency in agencies involved in health financing and reporting of health expenditures.

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