

Understanding Health Accounts: A Primer for Policymakers



What are Health Accounts?

Health Accounts encompass total health spending in a country – including public, private, household, and donor expenditures. Health Accounts carefully track the *amount* and *flow* of funds from one health care actor to another, such as the distribution of funds from the Ministry of Health to each government health provider and health service. In short, Health Accounts measures the “financial pulse” of national health systems and answers such questions as:

- ▶ Who in the country pays for health care? How much do they spend and on what types of services?
- ▶ How are funds distributed across different health services?
- ▶ Who benefits from health expenditures?
- ▶ What proportion of spending goes to HIV/AIDS, tuberculosis, or other specific disease areas?

The System of Health Accounts (SHA) is an internationally accepted methodology for summarizing, describing, and analyzing the financing of health systems. By systematically tracking the flow of expenditures in the health system SHA is critical for improving governance and accountability at the national and international levels of policymaking.

First published in 2000 by the Organization for Economic Cooperation and Development (OECD)¹, SHA was then adapted to the developing-country context in a version of the SHA called National Health Accounts (NHA) by the World Health Organization (WHO).² Over 100 developing countries have completed NHA estimations to inform health policy and measure health system performance. Recently, OECD, Eurostat, and WHO produced an updated version called SHA 2011³ that is known simply as “Health Accounts” (HA).

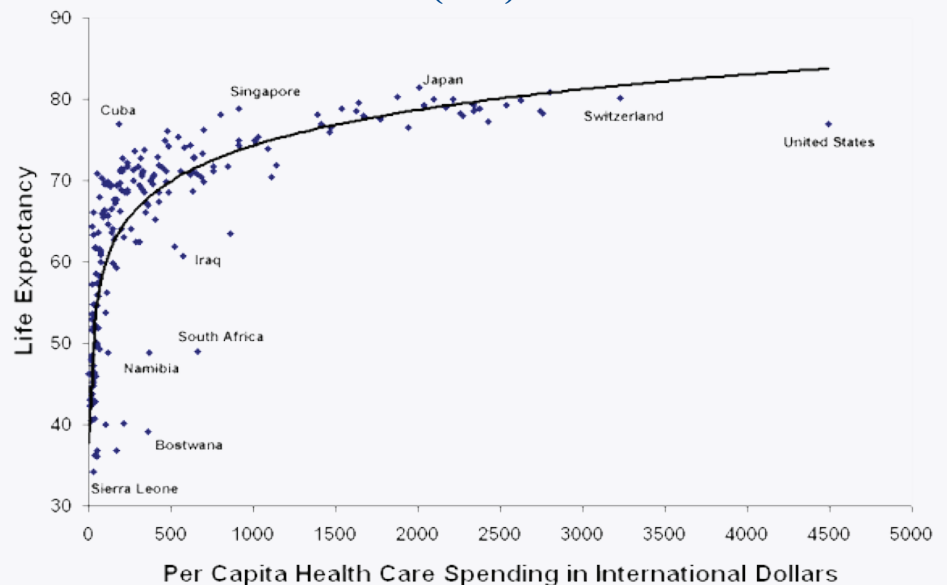
“[Health Accounts] afford us a better appreciation of the burden of out-of-pocket health financing borne by the general public and particularly people living with HIV/AIDS – evidence critical to the viability of the health insurance schemes we are currently developing.”

Tedros Adhanom Ghebreyesus⁵
2008 Minister of Health
Federal Democratic Republic of Ethiopia

Why Do I Need Health Accounts?ⁱ

As your economy and population grows, so will your country's spending on health. Countries can spend more on health compared to previous years and compared to their peers, but with the same or even worse health outcomes – see Figure 1. Granted there are many determinants of health outcomes besides sector spending, but you as a policymaker can affect public and private health spending to improve efficiency, quality, equity, and ultimately save lives. Health Accounts are your basic tool to determine what to do in terms of health financing policy and later determine whether those policies are working as intended.

Figure 1. Per Capita Health Spending versus Average Life Expectancy (2000)



Source: <http://ucatlas.ucsc.edu/spend.php>

Why Should I Have Confidence in Health Accounts Data?

Health Accounts uses strict criteria to consistently determine what to include and exclude as a health expenditureⁱⁱ in order to collect the best data to measure health expenditures:

- ▶ **Transparency.** There should be clear documentation of the sources of the expenditure data, the classifications and definitions used, and any adjustments or calculations. Typically, this requires preparation of a written manual for Health Accounts estimates in each country.
- ▶ **Policy relevance.** Health expenditure measures should be constructed to ensure inclusion of everything that is relevant to a country's health policy development efforts.
- ▶ **Measurement feasibility.** It should be feasible to compile and validate health expenditure measures within a reasonable time (less than a year) and cost.
- ▶ **Verification.** As part of the Health Accounts process, the local Health Accounts team identifies multiple sources of independent data for the same expenditures to allow for cross-checking and verification of health expenditures.

ⁱThis primer is an update of the Partners for Health Reformplus NHA primer.⁴ The document is intended to provide insight on how HA can support health systems policymakers and managers in their work to improve health system performance and management.

ⁱⁱSee glossary of health account terms in Annex I

How can Health Accounts Inform Policy?

Health Accounts is a tool specifically designed to inform the health policy process, including policy design and implementation, policy dialogue, and the monitoring and evaluation of policy changes. Health Accounts information is useful to the decision-making process because it is an assessment of the current use of resources and can be used to compare one country's health system with those of other countries – of particular value when setting performance objectives and benchmarks. If implemented on a regular basis, Health Accounts can track health expenditure trends to monitor and evaluate the impact of policy changes. Here are a few examples of policy impact:

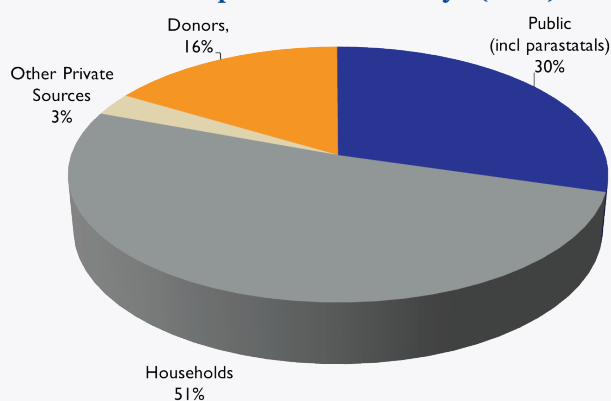
In **Kenya**, the Ministry of Health used Health Accounts data to mobilize more resources for health. Kenya's 2001/02 HA revealed that households finance 51 percent of the country's total health spending (Figure 2). In comparison, government contributed only 30 percent of total health spending. This high burden of health payments on households is significant given that over half of all households live in poverty. The Ministry of Health used the evidence from HA to justify and secure a 30 percent budget increase in 2006 from the Ministry of Finance. This represented its biggest budget increase since 1963.

In the early 1990s, **Egypt** launched the Health Insurance Organization for formal sector workers and later expanded coverage to children and widows. One of the goals of expanded insurance was to contain household out-of-pocket spending on health. Egypt conducted multiple rounds of HAs from 1994 to 2009 that revealed that household out-of-pocket spending increased as a percentage of total health spending. Expanding the Health Insurance Organization was not containing out-of-pocket spending. The Ministry of Health used the findings to propose a broader health insurance scheme.⁶

Reproductive health is a priority in **Namibia**; however, maternal and child mortality rates did not decline between 2000 and 2007. As part of its 2008/09 Health Accounts, Namibia conducted a deeper analysis of spending on reproductive health. Despite being a priority area, the HA found that reproductive health spending comprised only 10 percent of Namibia's total health expenditure (in comparison, HIV/AIDS spending represented 28.5 percent of total health spending), and most of the spending was from private sources (households and NGOs). Based on these findings, policy makers in Namibia looked for ways to increase the government's allocation to reproductive health. The Ministry of Health and Social Services has developed a Resource Allocation Criteria plan which is currently undergoing review.

Health Accounts is not only useful to ministries of health. **Civil society organizations** can use HA data to ensure people bring an informed voice to health policy. Prior to the 2002 HA in Kenya, civil society organizations had difficulty engaging in national debates because they didn't have access to the data they needed to substantiate their concerns. The 2002 HA showed that the government spent most of HIV/AIDS funding on prevention but did not contribute to ARV treatment (ART). Instead, households were the primary source of paying for ART. The Kenya Treatment Access Movement used these findings to lobby the government for an ART budget line-item to cover ART costs for poor Kenyans.

Figure 2. Households Dominated as the Source of Health Expenditures in Kenya (2002)



How Do Health Accounts Untangle the Flow of Funds Through a Health System?

The Health Accounts framework organizes and tabulates health spending data in a series of two-dimensional tables that show the flow of funds from one category of health care entity to another, that is, how much is spent by each health care category and to where those funds are transferred. Each health care category in the tables follows the International Classification for Health Accounts (ICHA) in the OECD SHA methodology.

The purpose of showing health fund distributions within tables and between tables is to understand the flow of funds through the entire system. As Figure 3 shows, these flows can be quite complex – as funds are often not simply channeled from one financing source to one type of provider, such as from government to government providers. Rather, health systems are much more complicated and entail numerous types of categories and health fund transfers. Using tables to plot the flow simplifies and clarifies the picture.

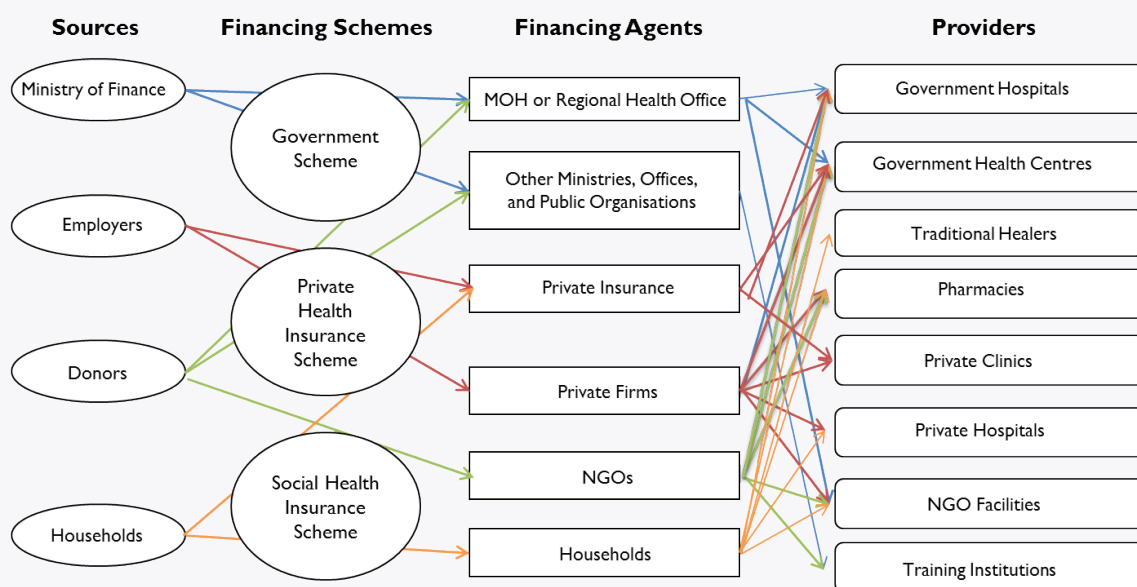
What Can I Do To Ensure That Health Accounts Serve My Country?

The best way to ensure that health accounts address the policy questions and issues that are a priority for your country is to get involved. Participate in defining the health system questions and issues that Health Accounts can shed light on, support the Health Accounts Team during the production phase, and make Health Accounts a routine, annual exercise in your health system. The first step, defining your health system questions and issues, is the most important step because more intense data collection can be planned for priority questions and issues. Health Accounts consists of several steps (Figure 4). Involvement of policymakers is critical at several points in the process to maximize the use of the data to improve your country's health system performance.

Figure 4: Health Accounts Steps

1. Define the health system questions and issues that Health Accounts can shed light on
2. Collect health expenditure data
3. Organize the data into the Health Accounts tables
4. Analyze the results for health policy
5. Disseminate the information to a wide range of stakeholders

Figure 3: Health Accounts Untangle the Complex Flow of Funds through a Health System



How Can Policymakers get involved?

Most countries establish two groups to successfully produce valid and reliable Health Accounts results that have credibility with decision makers: 1) a multidisciplinary Health Accounts team to do most of the detailed technical work, and 2) a more policy-oriented steering committee.

The Health Accounts team should be composed of members who work for various government agencies, both to ensure broad organizational representation and to access diverse data sources that otherwise might not be known to other team members. The team should include members who are familiar with national economic statistics and accounting practices, knowledgeable about health systems and policies, and experienced with data collection, data analysis and report writing. It is also very useful to have a health economist on the team to interpret the Health Accounts results.

The steering committee is for policymakers. It should include senior leaders from the Ministry of Health, Ministry of Finance, Ministry of Planning, and other high-level stakeholders from entities such as the National Statistical Office, academic groups, provider and consumer organizations, and the Social Health Insurance Organization. The committee's role is to guide and facilitate the work of the Health Accounts Team. Tasks include:

- ▶ Communicating policy concerns to the Health Accounts team before data collection begins
- ▶ Giving feedback to the Health Accounts team on results and findings
- ▶ Facilitating difficulties the team encounters while collecting data from different entities
- ▶ Assisting in interpreting the Health Accounts results and drawing policy implications
- ▶ Assisting the Ministry of Health in translating the policy implications into policy action
- ▶ Supporting the Health Accounts team in institutionalizing Health Accounts as a routine annual exercise.

How Can Policymakers Facilitate Data Collection?

The steering committee's role is to facilitate access to all potential data sources and support the Health Accounts team to substitute official statistics with more accurate estimates. Here are some data collection challenges that the Health Accounts Team may face and how you can help:

- ▶ **Records from national, regional, and local-level health authorities.** These records tend to be the most comprehensive, reliable, and accurate. However, they may not be up-to-date, because government accounts go through a lengthy auditing process. Auditing may create another problem, as it tends to generate two or sometimes three versions of total spending – an un-audited and audited.
- ▶ **Household survey.** Household surveys are undoubtedly the most important, possibly the only source of information on private (household) out-of-pocket expenditures. Household data are key for equity analysis, as they are linked to socioeconomic and demographic characteristics. Household surveys are expensive. The most efficient and sustainable option is to incorporate health expenditure questions into existing national household surveys that are conducted on a regular basis.
- ▶ **Donor assistance.** Often, annual surveys and routine reports of all donor assistance in a country (produced by United Nations Development Programme, WHO, or Ministry of Health) provide much of the necessary data. Nevertheless, issues arise with donor health expenditures: one is difficulty in determining the monetary value of in-kind donations (drugs, clinical supplies, vaccines). Another is the difference between amounts disbursed by the donor and the amounts expended by the recipient who can be the Ministry of Health or a private organization. Also, when donors disburse directly to nongovernmental organizations or other local entities without going through the ministry, the data are likely to be missed.

► **Insurer records (social and private).**

Insurer records should include premiums paid by households and companies to the insurer, and the insurer's medical and administrative costs. Private insurance companies may be reluctant to share some of their information, particularly their loss ratios and profits. Also, insurance records may exclude payments made by households directly to the provider (co-payments and deductibles). This is why a household survey is important.

- **Provider records.** These can be collected from the providers themselves or regulatory and financial agencies, such as tax authorities or licensing agencies. Often an industry association also collects routine data for its own purposes. As with private insurance companies, private providers are often reluctant to reveal their financial information for tax and other reasons, and a legal decree may be needed to mandate them to do so. Another potential issue is that, in some countries, it may be difficult to have a precise count of providers to get an accurate sample size for a survey. It is especially difficult to collect data from informal sector providers (traditional healers). A household survey with questions about where households seek care and how much they spend would address this challenge.

How Can I Ensure that Health Accounts Are Produced on a Routine Basis?

Institutionalization is the annual production and routine use of Health Accounts as an integral and sustained part of health system governance.

Here is what policymakers can do to institutionalize Health Accounts:

1. **Demand the data.** Request and use health expenditure data. Ask for the data to be presented in understandable formats, such as oral presentations and written briefs that stress policy-relevant aspects of the findings.
2. **Determine a location where Health Accounts is housed.** Health Accounts data should be housed in a location that will promote the use of the data by policymakers. Traditional locations include: the Ministry of Health, the Ministry of Finance, the central statistical bureau, a local university, or the central bank.
3. **Establish standards for data collection and analysis.** Data and reporting mechanisms should be standardized into a consistent format to allow for year-to-year comparisons. Incorporate health expenditure questions into an existing national household survey that is conducted on a regular basis. The Health Accounts team should keep track of the original methodology and any problems that arose during earlier rounds of Health Accounts. Maintaining records offers useful insights for streamlining the Health Accounts exercise and increasing the utility of results.
4. **Institute data reporting requirements.** Institutionalization of Health Accounts requires continual replenishment of data. By requiring the various Health Accounts-relevant groups to report data to the Health Accounts team, or at least to a central location, the reporting process is strengthened and becomes more integrated in to the Health Accounts structure.



What Support is Available for Health Accounts?

1. Tool to streamline production of health accounts

WHO and USAID developed a software application called the Health Accounts Production Tool (HAPT) (Figure 5) to streamline the production of HA by providing step-by-step guidance to in-country teams and automating much of the data input and calculations. HAPT is available in English, French, Spanish, Russian, Chinese and Portuguese at the WHO website (<http://who.int/health-accounts/tools/en/>). It includes:

- Step-by-step directions to guide country teams through the Health Accounts estimation process;
- Platform to manage complex datasets, reducing issues with missing data and version control;
- Survey creator and import function to streamline data collection and analysis;
- Built-in auditing feature to facilitate review and correction of double-counting of expenditures;
- Interactive diagram to help analysts visualize the flow of funding through the health sector; and
- Automatically generated Health Accounts output tables.

2. Tool to facilitate interpretation and use of health accounts

A second tool, the Health Accounts Analysis Tool (HAAT) complements the HAPT. HAAT assists with health expenditure data analysis by automatically producing relevant graphs and charts based on data in the HAPT. The HAAT is available for download from the WHO website (<http://who.int/health-accounts/tools/en/>).

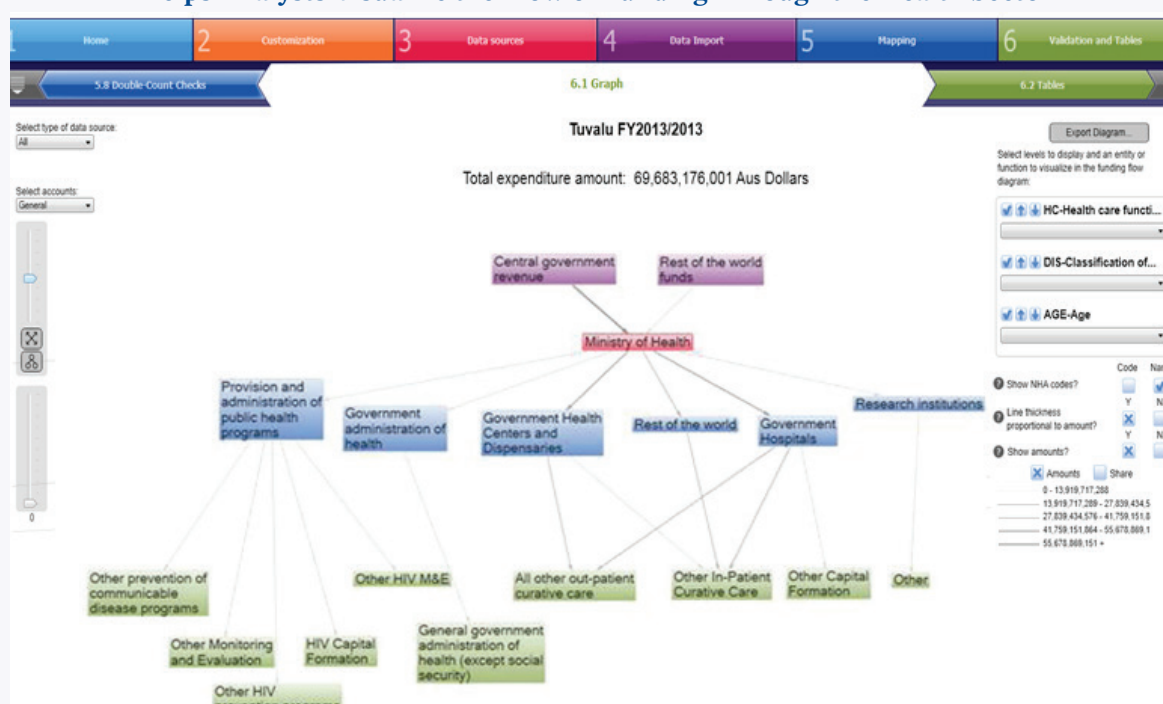
3. Technical assistance

USAID and WHO have resource tracking consultants that can assist your country in conducting a health accounts exercise. For more information, contact the WHO Health Accounts team at nha@who.int or the USAID/Health Finance and Governance Project Learnmore@hfgproject.org.

4. Health Accounts database

WHO maintains a Global Health Expenditure Database of Health Accounts data for countries. This database contains internationally comparable numbers on national health expenditures and can be accessed on the WHO website (<http://www.who.int/health-accounts/ghed/en/>).

Figure 5. The Health Accounts Production Tool's Interactive Diagram Helps Analysts Visualize the Flow of Funding Through the Health Sector





About HFG

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a five-year (2012-2017) global health project. To learn more, please visit www.hfgproject.org.

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Annex I: Health Accounts Glossary for Policy Makers

The Health Accounts methodology helps countries use consistent definitions and counting methods, which allows for cross-country comparability of health expenditure estimates.

Health Expenditure – all expenditures for activities whose primary purpose is to restore, improve, and maintain health for the nation and for individuals during a defined period of time. Budgets are not expenditures. Spending by the Ministry of Education on medical training and teaching hospitals is included. Not all activities conducted by the Ministry of Health are included, for example the Ministry of Health might fund the operation of orphanages, which would be deemed a non-health expenditure.

National Boundary – Health Accounts does not use the geographical borders of a country but rather looks at the health transactions of that country's citizens and residents. Therefore, it includes expenditure on health care by citizens and residents who are temporarily abroad and excludes spending on health care by foreign nationals within the country. Spending by international organizations on health and health-related goods and services for the residents of the recipient country are also considered national health expenditure.

Time Boundary – Health Accounts uses the "accrual" method to define its time boundary. Expenditures are recorded for the time period in which the health activity occurred (and corresponding expense was

incurred) and not when the actual payment is made. For example, if a hospital stay occurs during the final month of fiscal year 2013 but payment is made in fiscal year 2014, the expenditure is recorded for fiscal year 2013.

Classifications Health Accounts has at the core of its framework three classifications:

1. **Financing Schemes**, which show how goods and services consumed and provided are financed;
2. **Providers**, which show who delivers health care services; and
3. **Health Care Functions**, which show the types of health care consumed.

In addition to these core classifications, the SHA 2011 framework proposes additional classifications that are linked to the core classifications. These additional classifications are:

4. **Beneficiaries**, which show health care consumption by population groups (divided by age, disease burden, income quintile, etc.);
5. **Financing Agents**, the institutional units that manage health financing schemes;
6. **Factors of Provision**, which show the inputs used by providers to deliver health care services;
7. **Revenues of Financing Schemes**, which show the sources of funding for each financing scheme; and
8. **Capital Formation**, which compiles investments by health care providers, as part of the extended framework.

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