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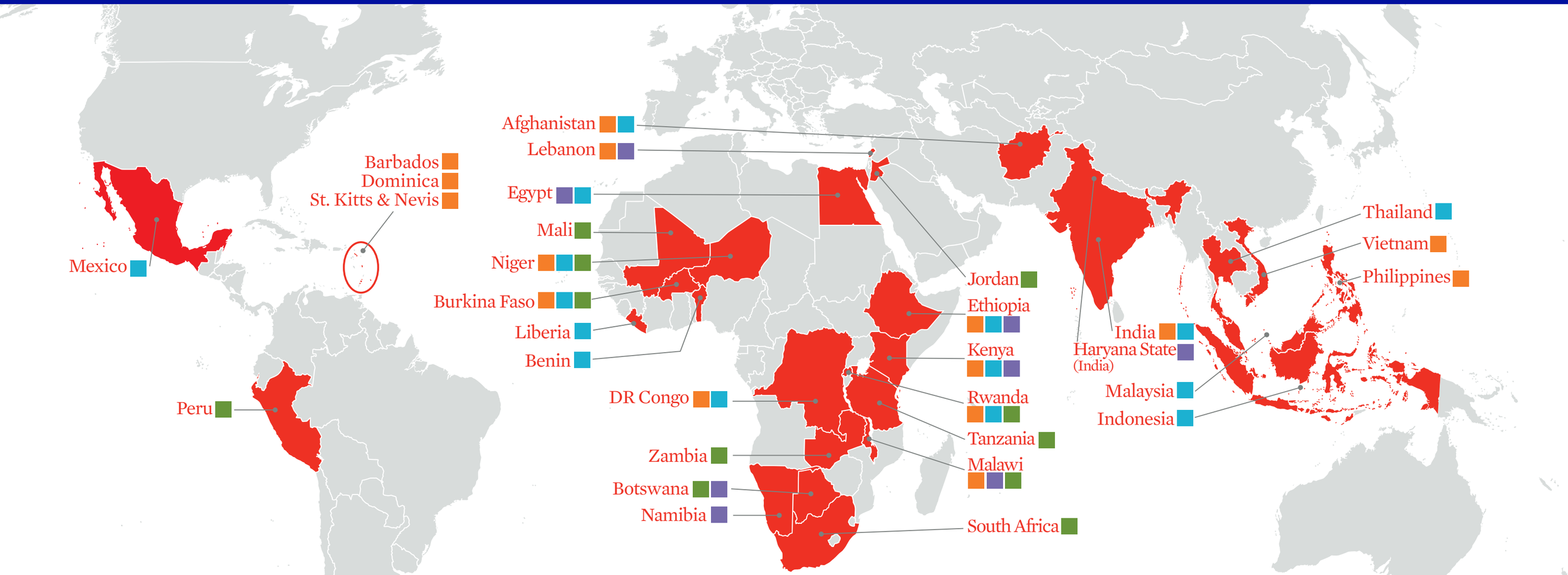
How have Health Accounts data been used to influence policy?

March 2018

Health Accounts Impacted Policy in over 30 Countries Worldwide



Health Accounts help countries to better raise, manage, and use funds for health

This brief compiles over 60 examples of how countries have used Health Accounts data to inform their health policy and planning decisions. The System of Health Accounts (SHA) is an internationally accepted methodology for summarizing, describing, and analyzing the financing of health systems. The SHA methodology is used by countries to produce their Health Accounts estimations. 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. The country examples in this brief are grouped by the type of policy use: 1) raising funds for health, 2) reducing financial risk for those seeking care, 3) allocating resources to priority health services, and 4) informing health planning. Additional details for each country can be found on the following pages.
For more details on Health Accounts, visit: ***https://www.hfgproject.org/resource-tracking/.***
Please note that while Health Accounts data contributed to the policies listed, the authors recognize that Health Accounts was not the sole source of data but rather was one of many contributing pieces of information informing the policy decision.

Raise Funds for Health

Includes initiatives to increase funding for health either by securing new funding, or by making better use of, and maximizing, existing resources (For example, through innovative financing mechanisms, the introduction of sin taxes, or revenue retention schemes in health facilities).

Reduce Financial Risk for Those Seeking Care

Pooling resources in the health system shares the financial risk associated with accessing health services across all members in the pool as opposed to each contributor individually and reduces the likelihood that an individual would incur catastrophic health expenditures when seeking care (Examples of risk pooling include: the introduction of national health insurance and community-based health insurance schemes and incorporating priority services into health benefit plans).

Allocate Resources to Priority Health Services

Efficient provision of health services ensures that a country's finite health funds are allocated to where they are needed most and will have greatest impact (For example, through greater investment at primary care level, or toward certain disease priorities).

Inform Health Planning

In some countries Health Accounts data provided background or landscape information for health system planning, monitoring, or to inform a potential policy reform.

Africa

Benin

USED FOR STRATEGIC PLANNING IN NATIONAL HEALTH PLAN

The 2003 National Health Accounts (NHA) estimation in Benin showed that the principal source of financing was household out-of-pocket spending, at 52 percent of total health expenditure. The government used these results for national strategic planning: the National Health Development Plan for 2009-2018 referenced the NHA results, and outlined intended strategies to address the situation, including the development of community-based health insurance in each district (Ministry of Health, n.d.).

Botswana

INCREASED FOCUS ON PREVENTION/PRIMARY HEALTH CARE

The 2012 Health Accounts for Botswana (covering the years 2007-10) revealed huge disparities in spending on preventive and curative care, with less than 10 percent of total health expenditure being spent on prevention. This led to the refocus of the health sector, where prevention is now the top priority of the health sector agenda. To reflect this priority, the Ministry of Health even added "wellness" to its name to become Ministry of Health and Wellness. The focus on wellness emphasizes promoting the physical and mental being of the population to prevent disease (Keti, 2016).

JUSTIFIED NEED FOR HEALTH FINANCING STRATEGY

The 2013/14 Health Accounts formed the basis for a landscape analysis and helped justify the need for a health financing strategy in Botswana. Health Accounts data on annual government spending, split by service costs and administration costs, informed an actuarial analysis to establish benefit package design and premium estimation (Kelly, 2017; Cali and Avila, 2016).

Burkina Faso

SUPPORTED MORE EQUITABLE NATIONAL BUDGET ALLOCATION TO HEALTH

Results of the 2012 Health Accounts were used to guide funding allocations by region. Burkina Faso's two poorest regions (Boucle du Mouhoun and Nord), with an incidence of poverty of 60.4 percent and 68.6 percent, respectively, achieved only 11 percent of all health expenditure due to a low allocation of health funding. In comparison, Central Region, where the poverty incidence is 22.3 percent, achieved 29.0 percent. The Health Accounts findings enabled redistribution of the partners' financing to give more funding to the two poorer regions (Ministry of Health, Burkina Faso, n.d.).

PROVIDED EVIDENCE FOR THE NATIONAL HEALTH FINANCING STRATEGY

The government of Burkina Faso is developing a national health financing strategy for universal health coverage (2016 to 2030) and Health Accounts data have provided key evidence in this strategy design. In 2010, the International Bureau of Labor Office used Health Accounts data as part of a feasibility study on the establishment of universal health insurance in Burkina Faso (Universal Health Coverage Partnership, 2015).

SUPPORTED REDUCTION IN OUT-OF-POCKET SPENDING

The 2014 Health Accounts showed that direct household payments for health represented a significant share (32.2 percent) of total health spending. This supported the removal of financial barriers to allow access to quality health care. In 2016, the government implemented a policy, Gratuité des Soins, which expanded the list of basic services provided free of charge. Between April 2016 and May 2017, the government increased its budget by USD $51 million to cover the free services, which previously, households would have had to cover (Ministère de la Santé Burkina Faso, 2017; Ridde et al., 2015).

SUPPORTED A REPRODUCTIVE HEALTH AWARENESS CAMPAIGN

Civil society used the Health Accounts data to advocate for health issues in Burkina Faso; for example, in 2009, Amnesty International used Health Accounts data to conduct an awareness campaign on reproductive health (Amnesty International, 2009).

INFORMED USE OF FUNDING IN THE HEALTH SECTOR

In 2010, during the final evaluation of the National Health Development Plan 2001-2010, the Health Accounts data were used to directing use of funding for health (Ministry of Health, Burkina Faso, n.d.).

Democratic Republic of Congo

SUPPORTED MECHANISM TO RAISE DOMESTIC FUNDS FOR HEALTH

Health Accounts data showing low government investment in health prompted the government to adopt an innovative mechanism to raise additional domestic funds for health. A law on health coverage calls for the government to co-finance a National Fund for Health Insurance (FONAM). This fund will also receive funds from additional 'sin taxes' imposed on products that can be harmful to health, such as alcoholic beverages, sugary beverages, and tobacco products (Mboko and Ladriere, n.d.).

INCREASED BUDGET ALLOCATION FOR HEALTH

Recommendations based on the Health Accounts estimates for the years 2008 to 2014 prompted the government to include certain public health services in the state budget, and increase services covered by the budget. Similarly, the government has allocated funds for health programs such as expanding immunization coverage of children including mass polio immunization campaigns for children, deworming with mebendazole, the fight against maternal neonatal tetanus, the regular supply of basic pharmaceutical products, and the renovation of health facilities (Présidence de la République Démocratique du Congo, 2012-2015; Ministère de la Santé Publique de la République Démocratique du Congo, 2014).

LED TO INITIATION OF PREPAYMENT MECHANISMS

The results of the DRC's Health Accounts and equity analysis prompted the president to set up a commission of experts to draft a law defining structures that will be responsible for collecting contributions as pre-payments, in particular, a National Agency for Health Insurance and community-based health insurance for selected health zones. In February 2017, the president promulgated the law on community-based health insurance. The government has set up a community-based health insurance scheme for teachers, to which the government contributes 50 percent of the premium. This initiative will extend to the rest of the population (Republique Democratique du Congo, 2017).

Ethiopia

INCREASED BUDGET ALLOCATION FOR HEALTH

NHA estimations were a critical input for budget negotiations at all levels (district, regional, and federal). NHA evidence is used during budget negotiations to advocate for more resources for health and the value that additional money can buy in terms of health outcomes (Alebachew et al., 2015). Government spending for health as a proportion of total health spending increased from 5.6% to 6.7% between 2011 and 2014 (Federal Democratic Republic of Ethiopia Ministry of Health, 2017).

SUPPORTED INTRODUCTION OF COMMUNITY-BASED HEALTH INSURANCE

High out-of-pocket spending on health led to a push for universal coverage in which Ethiopia piloted community-based health insurance for citizens in the informal sector, where the majority of Ethiopians work, and now is scaling it up to 343 districts (Health Finance and Governance Project, 2016). Preparation is also underway to implement comprehensive social health insurance for the formal sector (Feleke et al., 2015).

INSTIGATED FEE WAIVER FOR THE POOR

Health Accounts showed high out-of-pocket spending on health (accounting for over 50 percent in 1995/96 and 34 percent in 2010/11 of total health spending). In response, Ethiopia decided to protect the poor through a fee waiver system in which the poorest households are selected at the community level and receive certificates that guarantee their members access to free health services. Local administrations set aside a budget to reimburse health facilities for services rendered to the fee-waived beneficiaries (Alebachew et al., 2015).

INCREASED INVESTMENT IN PRIMARY HEALTH CARE

The first two rounds of NHA showed that the bulk of health resources were spent on hospital-level services that are concentrated in urban areas and are not serving the majority of Ethiopians, over 85 percent of whom live in the countryside. NHA evidence together with other sources of data was instrumental in benefiting the policy dialogue for more investment in primary health care and training of the low- to mid-level health workforce. It also contributed to the initiation and successful implementation of Ethiopia's flagship health sector program, the Health Extension Program, which provides packages of preventive, promotive, and basic curative services free of charge (Workie and Ramana, 2013).

SUPPORTED REVENUE RETENTION AT HEALTH FACILITIES

Ethiopia used National Health Accounts (NHA) results showing low levels of primary care spending to support revenue retention at health facilities – enabling health facilities to keep the user fees they earned and reinvest them in the facility on items like infrastructure, staff training, and purchase of drugs (HFG, 2017; MSH, 2017).

Kenya

SUPPORTED BUDGET INCREASE FOR HEALTH

Kenya's Ministry of Health used Health Accounts data to mobilize more resources for health. The ministry used the evidence from Health Accounts to justify and secure a 30 percent budget increase in 2006 from the Ministry of Finance. This represented its biggest budget increase since 1963 (Cogswell and Dereje, 2015).

INFORMED THE DESIGN OF HEALTH INSURANCE SCHEMES

The 2001/02 National Health Accounts (NHA) informed the discussion of social health insurance in Kenya, by revealing the inequities and unequal burden of financing on households. As a result, social health insurance is now included in Kenya's long-term development plan, Vision 2030 (Government of the Republic of Kenya, 2007). Results from various rounds of NHA (2005/06 and later) were used to inform the design of the national health insurance fund, which has not yet been fully implemented (Abuya et al., 2015).

LED TO REDUCTION OF USER FEES

Kenya's 2001/02 Health Accounts revealed that households financed 51 percent of the country's total health expenditure, whereas the government contributed only 30 percent. This financing burden on households is significant given that over half of them live in poverty. To reduce out-of-pocket expenditures and increase access, user fees were reduced in primary-level facilities in what is commonly known as the 10/20 Policy. This resulted in an over 50 percent increase in the number of outpatient visits (Chuma et al., 2009).

ENABLE CIVIL SOCIETY TO ADVOCATE FOR ANTIRETROVIRAL TREATMENT (ART) BUDGET

Civil society organizations used Health Accounts data to ensure the inclusion of the community's voice in health policy. Prior to the 2002 Health Accounts in Kenya, these organizations had difficulty engaging in national debates because they lacked data to substantiate their concerns. 2002 Health Accounts showed that the government spent most of its HIV/AIDS funding on prevention and did not contribute to ART – households were the primary source of ART financing. 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 (Cogswell and Dereje, 2015).

INCREASED GOVERNMENT RESOURCES FOR HEALTH

User fees, which households must pay out of pocket when seeking health care, accounted for 30 percent of funds allocated to operations and maintenance in health facilities. To reduce this financial burden for households, the Ministry of Health pilot tested a Direct Facility Funding (DFF) in Coast province. The objective of the DFF is to streamline the flow of financing in the health sector by providing grants directly to health facilities as funds allocated to districts rarely filtered down to the health centers and dispensaries. An evaluation of DFF revealed that there has been improvement in service delivery, including improvement in the physical state of facilities and equipment, maintenance of proper drug and supply stocks, reduction in patient waiting times, and increases in facility utilization (Opwora et al., 2009). This fund was promulgated in December 2007 and has been a pillar for decentralization of the health sector in Kenya (Waweru et al., 2013).

Liberia

INFORMED HEALTH FINANCING POLICY

2007/08 household survey data provided a critical input for new health financing policy by showing that the blanket "free health care" policy did not fully remove financial barriers for households seeking care. Out-of-pocket spending still constituted one-third of total health spending, reflecting substantial care seeking in the private sector and continued collection of fees in some public facilities. The results shaped the country's development of a new health financing policy, which will rely on general taxation, insurance, and limited user fees for a subset of services to be identified at the secondary/tertiary level (Liberia Ministry of Health and Social Welfare, n.d.).

Malawi

INCREASED BUDGET ALLOCATION FOR HEALTH

NHA results were used by the Ministry of Health to lobby for increased budget allocations to health in 2014/15. Under-investment in health sector and reliance on donor funding was linked to the overall poor quality of health services and supported increased budget allocations (Minister of Finance, Economic Planning and Development, 2014).

INFORMED HEALTH FINANCING STRATEGY

The 2006/07 and 2008/09 National Health Accounts (NHA) exercises provided the evidence to inform the development of a national health financing strategy in 2012. The NHA report was quoted in most parts of the health financing situational analysis section, which eventually informed the development of options for financing health in Malawi (contained in the draft Malawi Health Financing Strategy) (Zere et al., 2010).

CONTRIBUTED TO SERVICE LEVEL AGREEMENTS (SLAS) TO IMPROVE QUALITY

The NHA exercise covering 2002/03-2004/05 revealed large annual increases in household spending despite free public health care services, as well as increased donor and government spending on health. In 2006, the Ministry of Health began implementing SLAs, which defined maternal and newborn care services for which health facilities would be incentivized. The NHA findings provided evidence that, despite these agreements which guaranteed payments based on delivery of services, there had been very little increase in quality of care, and access to and utilization of public health care services, hence the need to strengthen the SLAs by increasing the number of services covered under the agreements and expanding the performance agreements to other NGOs including public sector facilities. A review of the SLAs and incorporation of the full concept of Performance-Based Financing are currently underway (Mpakati Gama et al., 2013).

REVISED RESOURCE ALLOCATION FORMULA

A major finding of the 2007 NHA was that the Ministry of Health's resource allocation to regions tended to follow available infrastructure rather than health needs of the population. To resolve this, the ministry embarked on revising the resource allocation formula that was developed in 2001. The 2007 NHA report provided evidence that there had been no change in spending patterns and emphasized the need to revise the formula (Boex et al., 2001).

Mali

INFORMED ANNUAL HEALTH SECTOR STRATEGIC PLAN

In Mali in 1999-2004, households contributed an average of 65 percent to total health expenditure, while government contributed an average of 17 percent, donors contributed 12 percent, and decentralized collectives contributed 6 percent. These results from the various rounds of National Health Accounts (NHA) were integrated into the 2008 annual Health Sector Strategic Plan (PROGRESS), especially in regard to human resources and health financing. The NHA results were also used to inform a multi-year (2007-2011) immunization program (Health Systems 20/20, 2011).

Namibia

INCREASED ALLOCATION TO REPRODUCTIVE HEALTH

The 2008/09 National Health Accounts (NHA) results sparked discussion on how to address inefficiencies in resource allocation. Notably, results from the NHA reproductive health analysis indicated that the strategic and funding objectives of the national Reproductive Health Roadmap were not being met. They also indicated that expenditure on reproductive health was only 10 percent of Namibia's total health expenditure (THE), while expenditure on HIV/AIDS was 28.5 percent, more than the amount that costing studies showed is necessary to reach HIV/AIDS strategic goals – this at a time when epidemiological data show that the maternal mortality rate is rising. Based on these findings, the Ministry of Health and Social Services has developed Resource Allocation Criteria to align resources with epidemiological conditions (Mbeeli et al., 2011; Zere et al., 2007).

Niger

INCREASED BUDGET ALLOCATION FOR HEALTH

The results of multiple rounds of National Health Accounts (NHA) made it possible to build solid arguments that were used for negotiation in the context of budgetary discussions with the Ministry of Finance and with the National Assembly. These negotiations have raised the budget allocated to the health sector, which explains the increasing absolute value of health spending in recent years (Republique du Niger, 2015a).

INCREASED BUDGET ALLOCATION FOR HEALTH

NHA results from 2004 indicated that household out-of-pocket spending accounted for 45 percent of total health expenditure, compared to 32 percent by the government. Policymakers increased the 2007 Ministry of Health budget by 49 percent from the previous year, citing evidence from the NHA (Republique du Niger, 2015a).

MONITOR PROGRAM TO REDUCE OUT-OF-POCKET PAYMENTS

Niger has used NHA results to strengthen the monitoring and evaluation of health programs. The NHA have shown that, despite the implementation of the policy of free targeted care (for under-five and pregnant women) adopted in 2006, households continue to pay heavily for their health care. Indeed, their contribution to national health expenditure increased from 47 percent in 2005 to 56 percent in 2013. This indicates not only problems in the implementation of the policy, but also the overall weakness of the health system to protect the health of those targeted for free care (Republique du Niger, 2015b).

INFORM SITUATIONAL ANALYSIS FOR UHC

Niger is establishing a national technical group responsible for the implementation of the country's universal health coverage work. In the area of strategic planning, NHA outcomes have been used as evidence in the situational analysis of health financing and governance issues in the sector. NHAs also direct decision-makers to better cost certain interventions by identifying key cost factors to focus on (Republique du Niger, 2012).

Rwanda

INCREASED DONOR FUNDING FOR HIV/AIDS

Rwanda's 1999 NHA that analyzed HIV/AIDS spending revealed that only 10 percent of all health funds were used to target the prevention and treatment of the disease. Households were the primary financiers of HIV/AIDS services, accounting for 93.5 percent of such funds, donors for 6 percent and the government for less than 1 percent. This evidence contributed to the donor community's decision to increase its HIV/AIDS-specific contributions from US$0.5 million in 1998 to more than US$1.6 million in 2000. In addition, NHA findings enabled the Ministry of Health to design and implement targeted policy interventions aimed at improving the financing of prevention activities and increasing access to basic health care services for people living with HIV/AIDS (Barnett et al., 2001).

REVISED PREPAYMENT SCHEMES TO INCLUDE HIV/AIDS INTERVENTIONS IN THEIR BENEFIT PACKAGES

Results from the 1998 National Health Accounts (NHA) indicated that HIV/AIDS treatment and prevention absorbed 10 percent of all spending in the health sector, and is disproportionately financed by households (93.5 percent). These results led several prepayment schemes to include HIV/AIDS interventions in their benefit packages (Schneider et al., 2001).

INCREASED BUDGET ALLOCATION FOR REPRODUCTIVE HEALTH

Though reproductive health remains a top priority for policymakers, the 2006 NHA showed that reproductive health accounted for only 6 percent of total health expenditure that year. The government and health planners used this information to advocate for and select family planning/reproductive health as one of the three strategic objectives in the Health Sector Strategic Plan II (Rwanda Ministry of Health, 2009).

South Africa

REDUCED ESCALATING DRUG COSTS

National Health Accounts results were used as evidence to reduce the escalating costs of drugs. South Africa introduced a "Single Exit Price" for all medicines. The Single Exit Price established the maximum price that providers could charge for each drug, providing certainty to patients about what they will have to pay for medicines and discouraging the inappropriate use of high-cost products (Swanepoel, 2006).

Tanzania

LED TO ADOPTION OF A SECTOR WIDE APPROACH (SWAp)

The first National Health Accounts (NHA) study conducted in Tanzania, in 1999, led to several significant policy developments. It showed the government that donors financed a significant portion of the health sector (approximately 23 percent) and that these funds were channeled "off-the-government" budget by donors bypassing the government and directly funding their own health programs. The government felt that this lessened its leadership of the health sector. To increase its stewardship and acquire some oversight of how health funds were used, the government used the NHA finding to advocate for the revision of donor coordination mechanisms and adoption of a SWAp. The SWAp encouraged most bilateral donors to channel their funds into basket funds managed by the government (Republic of Tanzania, 2007).

Zambia

INFORMED DESIGN OF ESSENTIAL HEALTH CARE PACKAGE

NHA results for 2005/06 informed the design of the essential health care package. Without NHA data, there was no information on actual health expenditure by all sources. This makes it very difficult to correctly determine what to include or exclude in the essential package, i.e., what could be an affordable essential health care package of cost-effective interventions (Wright and Health Finance and Governance Project, 2015).

EVALUATE IMPACT OF GLOBAL FUND SUPPORT

The current NHA results for HIV/AIDS, TB, and malaria for 2005/06 will be used in the evaluation of the Global Fund and other donors' contributions to health before and since the Global Fund was founded. This information will be critical in assessing whether Global Fund resources have been additional to government resources or not (Global Fund, 2017).

Asia and Central Asia

India

SUPPORTED ESTABLISHMENT OF NATIONAL RURAL HEALTH MISSION

India used Health Accounts findings to increase government investment in health through the establishment of the National Rural Heath Mission, a national initiative to support maternal, child, and reproductive health that has raised over US$3.3 billion since 2005 (Ministry of Health and Family Welfare, 2016).

INFORMED DEVELOPMENT OF HEALTH INSURANCE FOR THE POOR

Multiple analyses of population surveys have documented the impoverishing effects of out-of-pocket health expenditures among households near the poverty line. The surveys have contributed to the development of major reforms such as the National Rural Health Mission in 2005 and Rashtriya Swasthya Bima Yojna (RSBY) scheme in 2007, and to measure their impact on financial protection over time (Garg and Karan, 2009; Berman et al., 2010).

LAUNCHED FREE DRUG SCHEMES - HARYANA STATE (INDIA)

The major findings in the Haryana Health Accounts report showed very high out-of-pocket spending and low government investment in primary care. The Health Accounts data reinforced existing Haryana government efforts to launch free drugs and diagnostic schemes to help reduce out-of-pocket spending. The government has also substantially increased budget allocations for primary care services and staffing to improve access to those services (The Pioneer, 2013).

Indonesia

MONITOR IMPACT OF NATIONAL INSURANCE SCHEME

Indonesia is using Health Accounts to track progress toward universal health coverage by capturing the impact of a national insurance scheme on reducing out-of-pocket spending (Hidayat et al., 2015).

Malaysia

INFORMED NATIONAL HEALTH INSURANCE

National Health Accounts data from 1997-2014 revealed a high level of out-of-pocket spending – close to 40 percent of total health expenditure – risking catastrophic health expenditures and impoverishment of poor households. These data led to the proposal of a national health insurance scheme to provide an affordable prepayment mechanism for the general population. Contributions to the scheme would be based on a person's ability to pay. The government would provide assistance for disadvantaged groups. Malaysia now also has a line item in the annual budget to support the production and dissemination of NHA data going forward (Maeda et al., 2012).

Philippines

INCREASE FUNDING FOR LOCAL HEALTH PROGRAMS

Both national and local governments in the Philippines subsidize health care for the poorest 40 percent of the population. Data reveal that local governments' coverage of the poor is inconsistent and highly dependent on the availability of funds and priorities of the local governments. As a result, NHA has been implemented in 11 provincial-level pilots to track health spending. Its data have been used to increase central government funding for local public health programs, such as vaccination programs. In addition, NHA data identifies provinces where additional financing for health care is needed (Maeda et al., 2012).

MOBILIZE ADDITIONAL RESOURCES FOR HEALTH

National Health Accounts (NHA) data revealed a lack of health care coverage in the Philippines and an inconsistency between the national health insurance policy and the government's ability to implement the policy. While the Philippine Health Insurance Corporation was claiming 85 percent national insurance coverage, 2007 NHA data revealed that 55 percent of health financing came from households' out-of-pocket expenditures, and this financial burden was increasing. These results were the impetus to move policy discussions from "population coverage" to "effective coverage." This has led the government to mobilize more resources for health and to analyze the cost of possible changes to the depth and breadth of the benefit package (Maeda et al., 2012).

Thailand

INFORMED THE MOVE TO UNIVERSAL HEALTH COVERAGE

National Health Accounts (NHA) exercises in Thailand have informed the government's aims to promote universal coverage and ensure the long-term fiscal sustainability of the health sector. NHA data have been used to make long-term projections of health spending, disaggregated by major cost drivers like age category and geographic region. In 1994, NHA data revealed that household out-of-pocket payments provided 45 percent of total health expenditure, because a large proportion of the population (over 75 percent) were uninsured. These findings led to the development of the Universal Coverage health insurance scheme in 2002. The scheme extended coverage to those who were previously uninsured. NHA results were used to monitor how effective insurance was in reducing out-of-pocket spending. By 2008, NHA data revealed that households accounted for only 18 percent of total health expenditure (Maeda et al., 2012).

Vietnam

INFORMED FINANCING OF NATIONAL HIV STRATEGY

National Health Accounts (NHA) revealed a gap in financing for HIV/AIDS services. To address this gap, the Vietnam Administration of HIV/AIDS Control incorporated into the new national HIV strategy (i) plans for gradually increased domestic financing of the HIV program, (ii) expansion of the national health insurance package to cover HIV/AIDS (with a target of 80 percent of antiretroviral therapy (ART) being covered by insurance by 2020), and (iii) a greater role for the private sector in HIV service provision (Republic of Vietnam, 2004).

Afghanistan

INFORMED DOMESTIC REVENUE GENERATION STRATEGY TO INCREASE FUNDS FOR HEALTH

The 2008/09 NHA showed a low level of government expenditure on health, 6 percent of THE. In response, the Ministry of Public Health (MoPH) developed a revenue generation strategy to increase domestic funds for health. The MoPH also developed an advocacy plan to encourage earmarking of these funds for health and to increase the share of government spending on health out of the total government expenditure (Ministry of Public Health, 2014). This is also with the objective of making health financing more sustainable, by reducing the proportion of total health spending from donors (22 percent in 2011) (Ministry of Public Health, 2009).

SUPPORTED ESTABLISHMENT OF NATIONAL HEALTH INSURANCE

The 2012 National Health Accounts (NHA) findings on high out-of-pocket spending added urgency to efforts to build a health insurance program. The NHA estimation found that 73 percent of total health expenditure (THE) is made by households. This percentage is much higher than international norms, and highlighted the need for an insurance/risk-pooling mechanism to protect households from the risk of catastrophic health spending. In 2014, a health insurance feasibility study was conducted to identify options for covering people and reduce out-of-pocket spending (Zeng et al., 2017).

Latin America & The Caribbean

Barbados

INFORMED EXCISE TAX ON UNHEALTHY FOODS

The 2012/13 Health Accounts findings estimated spending by disease for the first time to help understand if it is aligned with the disease burden. The findings showed low spending on non-communicable diseases, despite the high prevalence of these diseases and the Ministry of Health's estimates that these disease will account for 86.3% of deaths in Barbados in 2030 (Pan American Health Organization, 2012). As a result, Barbados introduced a 10 percent excise tax on sugary drinks and food. The additional revenue will be used for health promotion and prevention to reduce the number of deaths from non-communicable diseases (Healthy Caribbean Coalition, 2016).

Dominica

INFORMED EXCISE TAX ON UNHEALTHY FOODS

Dominica used Health Accounts to align its spending with the disease burden. Health Accounts showed low spending on non-communicable diseases, despite the high prevalence of these diseases. As a result, Dominica introduced a 10 percent excise tax on sugary drinks and food. These additional revenues will be used for health promotion and prevention to reduce the number of deaths due to non-communicable diseases (Dominica News Online, 2015).

Mexico

ADVOCATED FOR SEGURO POPULAR

When Mexico's first National Health Accounts (NHA) estimation was conducted in 1994, it allowed for a comprehensive analysis of private out-of-pocket health spending that had never been done before. The NHA identified catastrophic health expenditures in low-income groups (household spending on health care that exceeds 30 percent of household disposable income). These results were used to advocate for a new insurance scheme, the Seguro Popular, to cover low-income groups that lack other insurance and thus avoid catastrophic expenditure on their part (World Bank, 2015).

Peru

INCREASED PUBLIC FUNDING AND REDUCED OUT-OF-POCKET SPENDING

Peru published its first Health Accounts in 2003 and the data have been used in the debate on universal health coverage, financing (increase of public expenditure and reduction of out-of-pocket expenses), and access to medicines. The analyses in the Health Accounts reports (2003, 2008, and 2015) have been a reference for technical documents, academic and political agreements like the National Agreement, and the Agreement of Political Parties in Health (Secretaría Ejecutiva del Acuerdo Nacional, 2014).

St. Kitts and Nevis

SECURED A BUDGET INCREASE FOR HEALTH

The country's first National Health Accounts (NHA) and HIV analysis estimation, in 2011, supported ownership and sustainability of HIV programming. The analysis highlighted strengths and weaknesses in St. Kitts and Nevis's health financing system and supported evidence-based planning and budgeting as well as efforts to achieve universal health coverage. In 2013, the Nevis Ministry of Health used evidence from the NHA to secure a 6.5 percent increase in the health budget in 2014 (Ministry of Finance, 2014).

Middle East

Egypt

INFORMED REVIEW OF HEALTH INSURANCE SCHEME

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. From 1994 to 2009, multiple rounds of NHA showed that household out-of-pocket spending increased as a percentage of total health spending even though coverage of the population through health insurance was increasing. 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 (El Fattah et al., 1997; Cogswell and Dereje, 2015)

INFORMED HEALTH FINANCING REFORM

The first round of National Health Accounts (NHA) 1994/95 stimulated discussion about rising out-of-pocket spending and the insufficient attention paid to outpatient and primary care, influencing the initiation of and planning for the Health Sector Reform Program in the late 1990s (World Bank, 1998).

SUPPORTED PROGRAM TO INCREASE GOVERNMENT INVESTMENTS IN HEALTH

Egypt's Treatment at State Expense public health care program was built based on the results of the NHA that showed high out-of-pocket spending. The program provides health care to underprivileged Egyptians who cannot afford to pay for medical treatment (Radwan, 2013). In 2016, the program reached 2.3 million patients at a cost of EGP 5.1 billion (Daily News Egypt, 2017). In 2009, the investment of about EGP 10 billion in Egypt's ambulance sector was based on the results of the 2008 NHA (Arab Reporters for Investigative Journalism, 2009).

ENHANCED ACCESSIBILITY AND QUALITY OF PRIMARY CARE FACILITIES

Findings from Egypt's second round of NHA, in 2001/02, which revealed high out-of-pocket expenditures on primary care, influenced the development of the Family Health Model, an important reform that systematized an efficient and sustainable framework for primary care facilities in the country to improve the quality and accessibility of health care services (El Rabbat and Bossert, 2012).

Jordan

INFORMED HEALTH SECTOR REFORM

The health sector reform program was implemented in Jordan by 1995. The database that was used to draft the working plan was derived from the results of the National Health Accounts study 1994 (World Bank, 1997).

Lebanon

INCREASED BUDGET ALLOCATIONS FOR HEALTH

National Health Accounts data supported mobilization of additional resources for health and the Ministry of Health Public Health was a pioneer in earmarking budgets for needed health items (Cashin and Bloom, 2016).

ELICITED PAYMENT MECHANISMS, PRIMARY HEALTH CARE POLICY, AND PHARMACEUTICAL POLICY

The 1998 Lebanon Health Accounts estimation led to major policy changes, in payment mechanisms, primary health care policy, and pharmaceutical policy. The second and third rounds of Health Accounts were used for tracking changes in the three policies (Van Lerberghe et al., 1997).

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The Health Finance and Governance (HFG) Project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

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- Enhancing governance for better health system management and greater accountability and transparency;
- Improving management and operations systems to advance the delivery and effectiveness of health care, for example, through mobile money and public financial management; and
- Advancing techniques to measure progress in health systems performance, especially around universal health coverage.

The HFG project (2012-2018) is funded by the U.S. Agency for International Development (USAID) and is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., the Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

The project is funded under USAID cooperative agreement AID-OAA-A-12-00080.

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This report was made possible by the generous support of the American people through USAID. The contents are the responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States Government.

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