

National Health Accounts (NHA) Subaccounts: Tracking Health Expenditures to Meet the Millennium Development Goals

MAKE THE MONEY COUNT

Over the past decade, international investment in health has increased at a rapid pace, exemplified by the dramatic rise in funding for HIV/AIDS, which grew from US\$292 million in 1996 to approximately US\$10 billion in 2007.¹ This additional funding is critical to make progress toward the three health-related Millennium Development Goals (MDGs), but whether or not this leads to actual improvements in health depends upon how the monies are spent.

Since 1990, many countries have made substantial progress toward meeting the MDG health indicators. The rate of new HIV

infections worldwide has started to decline since 2001, the use of insecticide-treated bed nets to prevent malaria has more than tripled since 2004, and the spread of tuberculosis is expected to begin to decline by 2015.²

Despite this progress, these health issues are far from resolved. During the same period, 27 African countries experienced no reductions in childhood mortality and worldwide maternal mortality decreased by less than 1% annually - a rate more than five times slower than what is needed to achieve the maternal health MDG.³

Although more funding will be needed to meet the MDG targets, governments, NGOs, and donors also need to make better use of existing funds. The aggregate statistics listed above mask wide variations from country to country, which reflect not only income levels and disease patterns, but also health spending decisions.

Ideally, health policy stems from a comprehensive understanding of the current health system, especially its exact monetary flows. Yet as the amount of financial assistance for health programs and the number of donors increase, it becomes more and more difficult to keep track of where all the funds are coming from and what they are being used for. Policymakers need a system to track the flow of fiscal resources in order to identify where funding is needed most and where it is likely to yield the highest returns for specific health indicators.

Currently implemented in over 100 countries, National Health Accounts (NHA) use an internationally recognized framework for measuring total - public, private, and donor - national health expenditures. NHA



Photo credit: Nancy Pielemeier

helps policymakers make better decisions about resources for health by presenting them with pertinent financial data in an easy-to-read tabular format. NHA estimates inform key national policy indicators, such as out-of-pocket household expenditures and the percentage of government spending that addresses health needs, while allowing for comparison with the performance of other countries.

WHAT ARE SUBACCOUNTS AND WHY ARE THEY NEEDED?

NHA subaccounts break down this aggregate health expenditure information by specific health issues, thus adding more precise instruments to the policymaker's toolkit. Subaccounts are currently conducted in the areas of HIV/AIDS, tuberculosis, malaria, reproductive health, and child health, with subaccounts under development for health information systems and mental health. Specifically, subaccounts ask:

- Who finances the program or disease area?
- How much is spent, and where do the funds go?
- Are funds reaching intended target populations?
- What is the burden of financing on households for specific health issues?
- Does spending support priorities and targets set out in national strategic plans for HIV/AIDS, malaria, or tuberculosis?
- What is the involvement of the informal sector in provision of health services?

By linking financial indicators to health outcomes, NHA subaccounts promote a robust monitoring and evaluation process, while encouraging transparency and accountability.

Additionally, donors can track progress toward program goals for specific health issues and verify that organizational policies - such as the Global Fund's policy of only providing financial assistance when it will not displace government funding - are being followed.

Organizations providing support for NHA include: World Health Organization (WHO); United States Agency for International Development (USAID); World Bank; GTZ; Swedish International Development Cooperation Agency (SIDA)

HOW ARE SUBACCOUNTS CONDUCTED?

NHA subaccounts are flexible enough to accommodate country needs but also follow a standard framework to ensure validity of data and facilitate country comparisons.

Subaccounts are not "studies"; rather they are intended to be a routine function of the government's health information system. They can serve as an integral policy tool for monitoring activities in priority health areas (e.g., HIV/AIDS, malaria, tuberculosis) to determine if funds have been spent as intended or to inform resource allocation decisions.

Subaccounts are normally conducted as part of a general NHA estimation and are ideally completed on a regular basis (every 2-3 years). Subaccounts are usually conducted by the same team that estimates the general NHA with the addition of a stakeholder representative for the target area. The team may include, for instance, a monitoring and evaluation specialist from the National AIDS Committee, or a finance representative from the National Malaria Program.

Subaccounts compile data from numerous primary and secondary sources to ensure estimates are comprehensive. In an effort to institutionalize the process, data are collected as much as possible from existing health information systems, other studies/reports, and ongoing surveys (Demographic and Health Surveys, NHA, etc.). Should data gaps remain, subaccount-specific surveys may be conducted.

PROVEN RESULTS

The value of NHA subaccounts for informing health policy has been demonstrated through more than 50 estimations carried out in over 25 countries to date, including subaccounts for HIV/AIDS, malaria, tuberculosis, reproductive health, and child health. Policymakers have successfully used data collected by NHA subaccounts to:

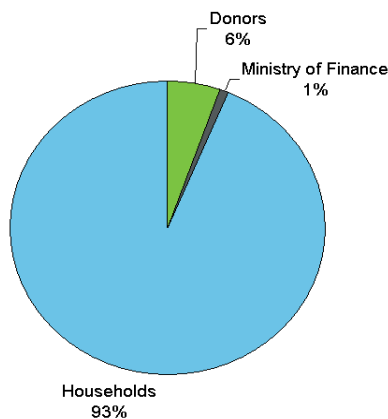
- Align policy and funding with national health goals and priorities.
- Mobilize resources for specific health issues and populations, making care more affordable for those who need it most.
- Monitor programs to make sure funds are being spent as intended.
- Increase transparency and accountability throughout the health sector.

POLICY IMPACT: CASE STUDIES FROM RWANDA, MALAWI, AND KENYA

INCREASING LEVELS OF DONOR FUNDING: RWANDA HIV/AIDS SUBACCOUNT

The Rwanda 1998 HIV/AIDS subaccount revealed that households bore an excessively large burden (93%) of the financing for HIV/AIDS-related expenditures, including antiretroviral therapy (ART). As a result, only a small fraction of the 400,000 people living with HIV/AIDS in Rwanda at the time received ART. Subaccount findings helped foster discussions among policymakers in Rwanda on the equity and efficiency of HIV/AIDS funding.

**RWANDA: HIV/AIDS EXPENDITURES
BY SOURCE (1998)**

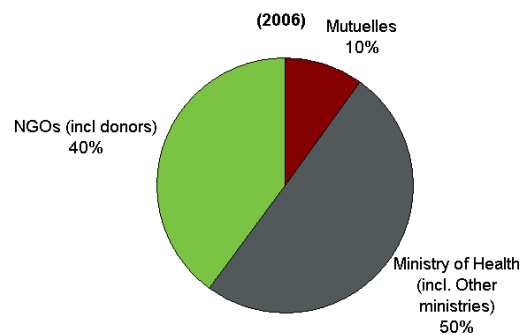
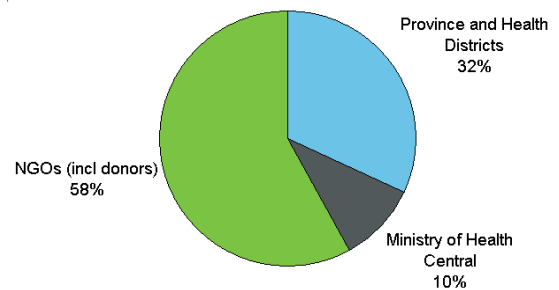


Moreover, the NHA results revealed a lack of donor funds directly targeted for HIV/AIDS. Despite financing half of the overall total health expenditures in Rwanda, donor funding accounted for only 6% of HIV/AIDS expenditures. This prompted donors to increase HIV/AIDS specific contributions from \$500,000 USD in 1998 to over \$1.6 million USD in 2000.⁴

INCREASING GOVERNMENT STEWARDSHIP AND DONOR HARMONIZATION: RWANDA MALARIA SUBACCOUNT

The 2003 malaria subaccount demonstrated that a large proportion of targeted funds were channeled through the NGO sector rather than through the ministry of health, limiting the government's ability to ensure that the various malaria programs were complementary and consistent with national priorities. This prompted the minister of health to advocate for greater government stewardship and increased harmonization of donor and governmental malaria activities.

**RWANDA: PROPORTION OF FINANCING
AGENTS FOR MALARIA (2003)**

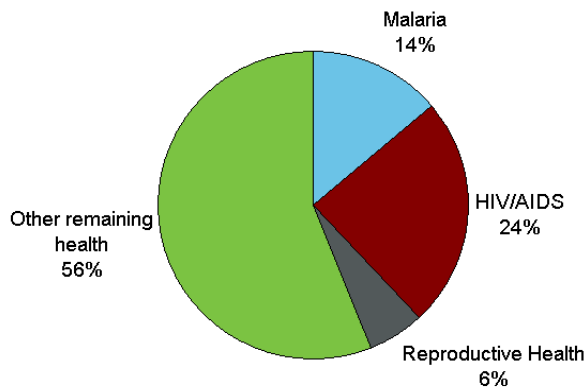


The 2006 malaria subaccount showed an increase in the percentage of health expenditures that passed through the ministry of health, facilitating the government's efforts to reduce socioeconomic disparities in access to malaria treatment.

DIRECTING ATTENTION TO SPECIFIC HEALTH ISSUES: RWANDA REPRODUCTIVE HEALTH SUBACCOUNT

According to the Rwandan Integrated Living Conditions Survey, the current economic growth rate in Rwanda is insufficient to support the rapid population growth fueled by high birth rates.⁵ Though reproductive health (RH) remains a top priority for policymakers, the 2006 RH subaccount showed RH accounted for only 6% of total health expenditures in 2006. The government and health planners used this information to advocate for and select family planning/reproductive health as one of the four priority areas in the 2008 Rwandan Joint Annual Health Work Plan.

RWANDA: BREAKDOWN OF TOTAL HEALTH EXPENDITURES (2006)



COMPARING POLICY EFFECTIVENESS ACROSS COUNTRIES: MALAWI CHILD HEALTH SUBACCOUNT

Analyzing FY2003-05 data, the 2007 child health subaccount revealed that Malawi spends a comparable amount on child health when compared to other countries with similar economic profiles, such as Sri Lanka. However, Malawi's under-five child mortality is much higher, nearly nine times that of Sri Lanka. These NHA findings prompted governmental discussions on the need to review current health financing practices and health policies.

Currently, Malawi is considering alternative financing mechanisms such as performance-based financing in order to

increase efficiency and transparency. The child health subaccount findings bolstered the advocacy of the Ministry of Health Planning Department for performance-based financing in order to hold providers accountable for key child health output indicators such as immunization coverage.

STRENGTHENING CIVIL SOCIETY: KENYA HIV/AIDS SUBACCOUNT

Civil society organizations (CSOs) play a vital role in democracies. They ensure that people have a voice in their government and are pivotal in the fight against corruption.⁶

CSOs had difficulty engaging the Kenyan government in national debates, due in part to the paucity of data available to them. The 2002 HIV/AIDS subaccount reported that the government spent most of their HIV/AIDS money on prevention and did not contribute to ART.

The Kenya Treatment Access Movement used these findings to lobby the government for an ART budget line-item and to gain a more prominent role in policy discussions.

CONCLUSION

Subaccounts, when used as a routine resource tracking instrument, provide a powerful tool for a variety of stakeholders in society, from domestic policymakers to international donor agencies, to more effectively allocate resources and, consequently, increase the conversion rate from health expenditures into health returns.

ENDNOTES

- 1 Total annual resources available for AIDS 1986-2007. UNAIDS. Available from: http://data.unaids.org/pub/GlobalReport/2008/2008_globalreport_figure7_01_en.ppt
- 2 United Nations Millennium Development Goals Fact Sheets. Available from: <http://un.org/millenniumgoals>
- 3 United Nations MDG Fact Sheets.
- 4 Barnett, C., M. Bhawalkar, A.K. Nandakumar, and P. Schneider. Feb 2001. The Application of the National Health Accounts Framework to HIV/AIDS in Rwanda. Special Initiatives Report No. 31. Bethesda, MD: Partnerships for Health Reform. Abt Associates, Inc.
- 5 Ministry of Finance. (2002). Final Report: Integrated Household Living Conditions Survey in Rwanda. Kigali, Rwanda: Republic of Rwanda.
- 6 Organization for Economic Co-operation and Development. (2003). Fighting Corruption: What Role for Civil Society? The Experience of the OECD. Paris: OECD Publications.

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