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Policy Primer: Using Health Accounts to End Preventable Child and Maternal Deaths



Introduction

Ending preventable child and maternal deaths is at the forefront of country and development partner health agendas. While progress has been made over the last few decades, significant challenges remain. Of all of the Millennium Development Goals (MDGs), the least progress has been made toward Goal 5 – Improving maternal health. In fact, “every day, nearly 800 women across the globe die due to complications during pregnancy and childbirth, and 99 percent of these deaths occur in developing countries” (World Bank 2015a). Similarly, under-five mortality rates remain high – less than half of all countries will meet the childhood mortality MDG target (World Bank 2015b).

Improving health outcomes for mothers and children requires sufficient funding for efficient and high-impact interventions. Policymakers need current and detailed information on the gap between resources currently available for maternal and child health (MCH) and the investments required to achieve national targets. Health Accounts is a key tool to generate the evidence to assess whether existing resources are sufficient and whether they are being spent on the most effective interventions. This evidence is critical for informing MCH policies and plans.

Health Accounts exercises are only useful insofar as the findings are used to inform health policy. This primer is intended to enhance uptake and use of MCH findings by government officials and health system policymakers and managers in their work to improve health system performance. It emphasizes the importance of regular tracking of MCH spending data and showcases how this information can be interpreted and used by discussing several country examples.

Health Accounts: An Expenditure Tracking Framework

The Health Accounts framework is an internationally standardized approach that allows a country to track the **amount** and **flows** of money through its health sector in one year (see Box 1). Health Accounts are critical to understanding past spending on health in order to inform future spending decisions. Government officials have used Health Accounts findings to help identify inequities in the distribution of funding across districts or categories of health care as well as evaluate a country’s progress toward achieving strategic health objectives.

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Box 1: Overview of Health Accounts Methodology for Policymakers

Health Accounts is a methodology that enables countries to estimate their total health expenditures, including public, private, and donor contributions, for a given year. Health Accounts tracks the flow of health funding from source to agent to provider to final function or activity. In doing this, Health Accounts promotes evidence-based decision making and responds to critical questions, such as:

- Who pays for the country's health services?
- Who are the different financing agents that manage the allocation of funds?
- What providers or implementers receive funding?
- What specific health services and activities are being financed?
- What is the spending breakdown by disease?

To date, over 100 developing countries have completed Health Accounts estimations, many with special sub-analyses of reproductive health and child health spending. More than 20 rounds of reproductive health analyses have been conducted and over 10 rounds of child health analyses have been conducted. Several countries have completed multiple rounds of MCH analyses: the Democratic Republic of Congo, Ethiopia, Jordan, Kenya, Liberia, Malawi, Namibia, Rwanda, Senegal, Tanzania, Uganda, and Ukraine. Since the revised, more detailed 2011 Health Accounts framework was adopted, 12 countries have completed a full disease breakdown, which includes tracking of maternal health and child health spending, and approximately 20 countries are in the process of estimating expenditures across all disease categories with this updated framework.

When Health Accounts estimates are produced regularly over multiple years, the findings can be used to identify trends and discrepancies in budget allocations over time. Health Accounts data can also be used to compare the health system spending of different countries.

Recent developments in Health Accounts to better track MCH spending include the following:

1. **MCH spending consistently tracked in SHA 2011 methodology.** In a previous version of the Health Accounts methodology known as "National Health Accounts," disease spending was tracked in separate sub-accounts. Now, with the latest version of Health Accounts methodology, known as "System of Health Accounts" (SHA 2011), a full breakdown of spending across disease categories, including maternal health and child health, is collected as part of the overall framework. This is a useful development for tracking MCH expenditures; previously, countries needed to choose to track MCH-related spending for those sub-categories to be tracked, but now, spending on these areas is consistently and automatically tracked as part of every Health Accounts exercise.
2. **Improved guidance for tracking maternal health and child health.** To assist with tracking MCH resources and to enable countries to track a more detailed breakdown of MCH spending, guidance documents for tracking maternal health and child health spending using the SHA 2011 framework are currently being developed by WHO and partners. This special guidance will enable countries to produce a more detailed breakdown of maternal health-specific spending, which under NHA was previously combined with other reproductive health spending.

What Types of MCH Questions Can Health Accounts Address?

Health Accounts can also allow policymakers to answer questions about spending on specific health problems or disease areas. As shown in Box 2, maternal health captures spending during pregnancy, childbirth, and the first six months after delivery. Child health includes all goods and services delivered to the child after birth up to age five whose primary purpose is to restore, improve, or maintain health. Health Accounts estimations can answer the following questions about spending related to MCH:

- ▶ How much is spent on maternal health care? What share of total health expenditure is allocated to child health?
- ▶ How much does the country rely on donors for maternal health services and commodities?
- ▶ What share of public health funds is spent on child health? What role does the private sector play?
- ▶ What is the financial burden on households to pay for maternal health care?
- ▶ Are expenditures in line with resource needs as outlined in national MCH plans?
- ▶ What types of services are financed by child health funds? How much is spent on preventive and curative services?
- ▶ What proportion of maternal health expenditure is for treatment in hospital and what proportion for outpatient care?
- ▶ Who benefits from maternal health spending?
- ▶ What is the difference in per capita expenditure on child health between insured and uninsured individuals?
- ▶ How does financing of maternal health and child health services compare among countries?

Box 2. Which Services Are Classified Under Maternal Health and Child Health in Health Accounts?

Maternal health expenditure includes:

- Antenatal care
- Delivery care
- Postpartum care

Child health expenditure includes:

- All goods, services, and activities delivered to the child after birth or its caretaker, whose primary purpose is to restore, improve, and maintain the health of children between zero and less than five years of age
- Expenditure on breastfeeding
- Integrated management of sick children
- Immunizations
- Insecticide-treated bed nets

Why Monitor Expenditures on MCH?

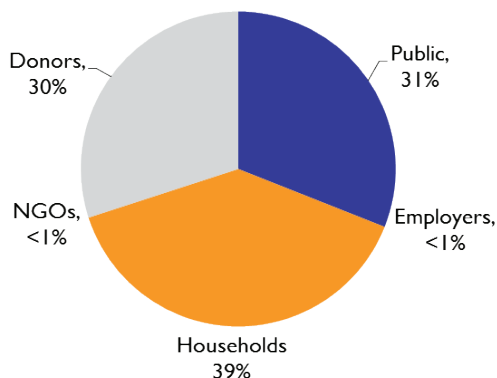
The World Health Organization (WHO) recommends regular expenditure tracking.

Financing for MCH matters if we wish to guarantee the fundamental human right of every woman and child to have access to quality health care. The WHO recommends that countries track health expenditure data on an annual basis. The Commission on Information and Accountability (COIA) for Women's and Children's Health, a forum of international stakeholders from developing countries, donor governments, multilateral organizations, civil society, and the private sector, has developed recommendations to ensure accountability for resources pledged for women's and children's health and to ensure that results are measured. Three of COIA's 10 recommendations directly relate to better tracking of resources for MCH. As part of Recommendation 4, countries with high maternal and child death rates should regularly track at least the following two aggregate resource indicators: 1) total health expenditure per capita, by financing source; and 2) total MCH expenditure (in addition to other categories) by financing source, per capita (WHO 2015a).



Expenditure tracking enables data-driven decisions. Policymakers and decision makers need to have the capacity to regularly review spending on MCH to know: How much is spent on MCH? By whom? And for what services? The detailed expenditure information from Health Accounts holds decision makers accountable to their commitments as expressed in their national health strategic plans and also in other MCH goals. It allows policymakers to assess the level of distribution and resources and how that distribution aligns with health sector priorities, evaluate the sustainability of financing over time, and improve allocation of current spending – thereby reducing waste and improving efficiency.

Figure 1. Households Were the Largest Source of Health Funds in Burkina Faso, 2006



How Have Health Accounts Informed MCH Policy?

The following are country examples of how Health Accounts data have been used to inform MCH policy.

Burkina Faso reduced out-of-pocket payments for maternal health services¹

In Burkina Faso, Health Accounts data were crucial for reducing out-of-pocket (OOP) payments for priority maternal health services, including the cost of normal deliveries, cesarean sections, and emergency obstetric care. OOP spending causes households to bear the full cost of health goods and services at the time of seeking care, imposing a barrier to access and representing a significant financial burden for individuals and families. High levels of OOP payments are inequitable and consistently prove to be an inefficient means of financing health care. Burkina Faso's Health Accounts data revealed that household spending accounted for the largest share (39 percent) of total health expenditure (see Figure 1) (Ministry of Health Burkina Faso 2008). The WHO (Xu et al. 2010) has calculated that OOP spending at the high levels seen in Burkina Faso results in households incurring catastrophic health expenditure, pushing some households below the poverty line.

In response to this finding, and to reduce the OOP burden on households, policymakers in Burkina Faso decided to subsidize certain key medical services. For normal deliveries and emergency obstetric care (including cesarean sections), the government now covers 80 percent of the cost (Zida et al. 2010). As a result, the price of normal deliveries (in real 2010 USD) decreased from US\$4.10 per delivery in 2006 to US\$1.50 in 2010, and the price of emergency obstetric care decreased from around US\$121 to US\$22 per patient. Individuals and families are now able to access priority maternal health services without the added stress of incurring financial hardship in the process.

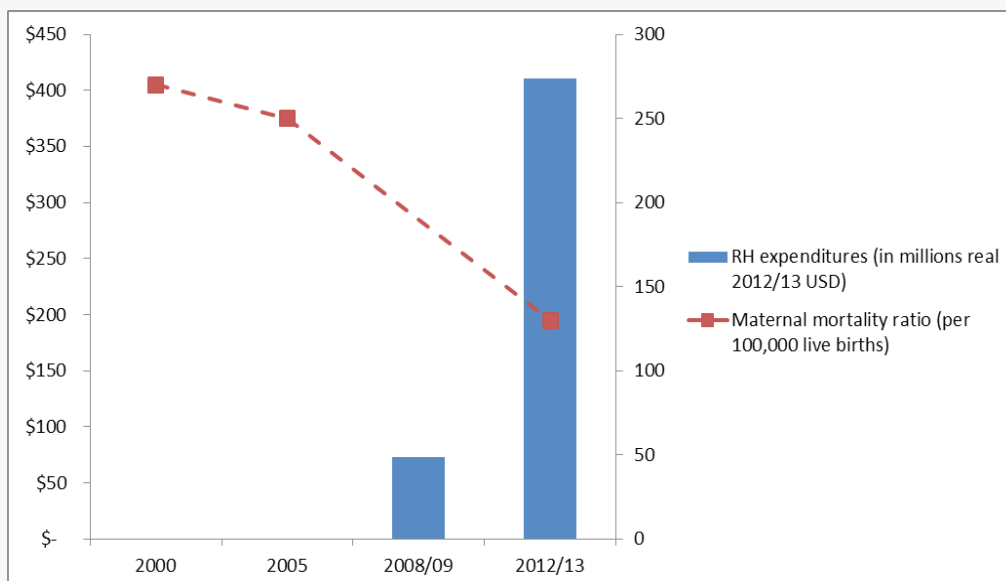
¹ Adapted from Zida et al. (2010).

Health Accounts findings drove the allocation of more funding to reproductive health services in Namibia²

While reproductive health is a priority in Namibia, maternal and child mortality rates did not decline substantially between 2000 and 2007. As part of its 2008/09 Health Accounts exercise, Namibia conducted a deeper analysis of spending on maternal and reproductive health. Despite this being a priority area, the analysis 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 (NGOs and OOP spending by households). Based on these findings, policymakers in Namibia looked for ways to increase the government's budget allocation to reproductive health. The Ministry of Health and Social Services developed a Resource Allocation Criteria Plan to work to allocate more funding to maternal and reproductive health.

The latest Health Accounts estimation (for 2012/13) reveals that maternal and reproductive health now receives the highest allocation of funds, 38 percent of total health expenditure (36 percent on maternal health services, 2 percent on family planning and other reproductive health services) compared to other diseases/priority areas. This represents over a 400 percent increase from 2008/09. Figure 2 shows Namibia's total spending on reproductive health in real 2012/13 USD over the last two rounds of Health Accounts data. It also shows that Namibia's maternal mortality ratio between 2000 and 2005 remained relatively constant, averaging 260 maternal deaths per 100,000 live births (WHO 2015b). However, by 2013, concurrent with the increase in overall spending on reproductive health, it had dropped to 130 maternal deaths per 100,000 live births. While we cannot say that the increased spending on reproductive health drove the reduction in the maternal mortality ratio, the Health Accounts analysis did drive an increase in spending on reproductive health, and this likely contributed to reduced maternal mortality.

Figure 2. Reproductive Health Expenditure and Maternal Mortality Ratio in Namibia



² Adapted from Cogswell and Dereje (2015).

Health Accounts help civil society advocate for greater access to reproductive health services³

Health Accounts data and reports are meant to serve as a reference not only for government institutions but also for civil society and international partners. For example, Amnesty International used information from Burkina Faso's 2008 reproductive health analysis to support its campaign to raise awareness and promote policy change regarding maternal mortality and women's fundamental right to health care. An Amnesty International report (2009, p. 18) that discussed Burkina Faso's high maternal mortality rate used Health Accounts findings to show that only 6 percent of the total health budget was going to reproductive health. Only 5 percent of the reproductive health budget (0.02 percent of the total health budget) was spent on maternal health and family planning. Amnesty International argued that while the government had prioritized maternal health in the National Health Development Plan, the budget remained insufficient to achieve its specific objectives. In this way, Health Accounts buttressed Amnesty International's push to help women gain access to sexual and reproductive services, improve the quality and acceptability of care, and ultimately ensure government accountability.

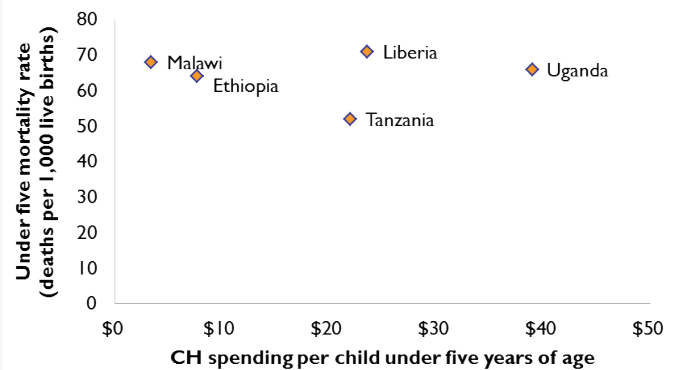


³ Source: Zida et al. (2010).

Cross-country analysis for benchmarking country performance⁴

In addition to tracking individual performance over time, countries are eager to see their performance on health indicators relative to their peers. Health Accounts is an internationally standardized methodology that enables cross-country comparisons. An analysis of health spending per child under five years of age (Figure 3) shows that countries can spend more on child health services compared to their peers, but have the same or even worse health outcomes. Health Accounts allows policymakers to see the absolute value of health expenditure in one country, relative to its peers; when combined with health outcome or service coverage data, this benchmarking can help incentivize policymakers and practitioners to spend that money more efficiently and accomplish more per dollar spent.

Figure 3. Child Health Spending Per Capita vs Under Five Mortality Rate



⁴ Source of under five mortality rates: http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/APR-2014-17Oct14-web_194.pdf

How Can Policymakers Support the Use of MCH Health Accounts Data?

The best way to ensure that Health Accounts address the MCH policy questions and issues that are a priority for each country is for policymakers to get involved in the process from the beginning. Ideally, policymakers should participate in defining the health system questions and issues that Health Accounts exercises focus on; support the Health Accounts team during the data collection and analysis phase; and make Health Accounts a routine, annual health system exercise. In addition, policymakers should join the Health Accounts steering committee to guide and facilitate the Health Accounts estimation process, including:

- ▶ Communicating policy concerns to the Health Accounts team before data collection begins.
- ▶ Providing feedback to the Health Accounts team on results and findings.
- ▶ Assisting with interpreting the Health Accounts results and drawing policy conclusions.
- ▶ Assisting the ministry of health in translating policy implications into action.
- ▶ Supporting the Health Accounts team in institutionalizing Health Accounts as a routine annual exercise, including integrating data collection into routine/existing systems. By collecting Health Accounts data on a regular basis, the government can study how funds are actually being used in the health sector year after year. This insight may help policymakers better prioritize critical health services and functions.
- ▶ Asking for the results to be disseminated in a way that facilitates use, for example, in the form of analytical briefs that address key policy questions.
- ▶ Disseminating the results to a wide stakeholder community. Making Health Accounts data publicly available to all actors reinforces a high degree of transparency over the allocation and use of financial resources. This, in turn, increases participation and public interest in health governance and the system at large.





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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References

- Amnesty International. 2009. *Giving Life, Risking Death: Maternal Mortality in Burkina Faso*. London: Amnesty International Secretariat. Accessed on June 10, 2015 at http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/AI_Burkina_Faso47.pdf
- Cogswell, Heather, Tesfaye Dereje. January 2015. *Understanding Health Accounts: A Primer for Policymakers*. Bethesda, MD: Health Finance and Governance project, Abt Associates.
- Ministry of Health Burkina Faso. December 2008. *Stratégie Nationale de Subvention des Accouchements et des Soins Obstétricaux et Néonataux d'Urgence au Burkina Faso*. Accessed on June 10, 2015 at <http://uaps2011.princeton.edu/papers/110919>
- World Bank. 2015a. *Millennium Development Goals: Goal 5 Improve Maternal Health by 2015*. Accessed on May 15, 2015 at http://www.worldbank.org/mdgs/maternal_health.html
- World Bank. 2015b. *Millennium Development Goals: Goal 4 Reduce Child Mortality by 2015*. Accessed on May 15, 2015 at http://www.worldbank.org/mdgs/child_mortality.html
- WHO. 2015a. *Commission on Information and Accountability for Women's and Children's Health*. Accessed on May 15, 2015 at http://www.who.int/woman_child_accountability/about/coia/en/index5.html
- WHO. 2015b. *Global Health Observatory Data Repository: Maternal Mortality Ratio Data by Country*. Accessed on May 22, 2015 at <http://apps.who.int/gho/data/node.main.MATMORT?lang=en>
- Xu, Ke et al. 2010. *Exploring the thresholds of health expenditure for protection against financial risk*. World Health Report Background Paper, No. 19. Geneva.
- Zida, André, M. P. Bertone, L. Lorenzetti. December 2010. *Using National Health Accounts to Inform Policy Change in Burkina Faso*. Policy Brief. Bethesda, MD, USA: Health Systems 20/20, Abt Associates.