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Production and Use of Health Accounts in India: What Can We Learn from the Experience so Far?

Background

Health systems worldwide are expanding their capacity to improve people's welfare. Governments and their development partners in low- and middle-income countries are depending on data to inform health financing decisions, monitor health sector performance, and exercise stewardship. Recognition of the value of health resource data has built momentum for health resource tracking – measuring health spending and tracking the flow of financial resources among health sector actors. One powerful resource tracking mechanism that countries are using is National Health Accounts (NHA).[1] The NHA methodology can be applied to both national- and state-level spending. For clarity, this brief will refer to national-level health accounts as "NHA" and state-level health accounts as "SLHA."

Recognizing its value, India has conducted multiple rounds of health accounts at the national and state level. The purpose of this brief is to describe the findings and lessons learned from these exercises.

Health Accounts at the National and State Level

India has done two rounds of NHA: the first round, completed in 2006, estimated health expenditures for fiscal 2001/02; the second round was completed in 2009, for 2004/05 expenditures[2]. The Ministry of Health and Family Welfare (MoHFW)'s National Commission on Macroeconomics and Health (NCMH) in 2006 further disaggregated first-round NHA estimates.

The 2004/05 NHA revealed that household out-of-pocket expenditure constituted more than 70 percent of the total expenditure on health in India (Figure 1) (MoHFW 2009). These NHA results helped to inform and frame the national-level health insurance scheme called the Rashtriya Swasthya Bima Yojana (RSBY). RSBY provides financial protection to the poor and reduces their out-of-pocket expenditure on health. The insurance scheme specifically targets the informal sectors and populations living below the poverty line.

[1] NHA is an internationally standardized health resource tracking methodology. NHA tracks the flow of resources in a country's health system. It captures spending by the public sector, private sector including households, nongovernmental organizations (NGOs), and donors.
[2] The delays in publication were mainly due to input of data for household expenditure estimates, which comes from the National Sample Survey Organization.

*This brief was authored by **Bhavesh Jain, Heather Cogswell** and **Tesfaye D Ashagari**, for the Health Financing and Governance project, June 2014.*

How Other Countries are Using NHA

To date, over 100 (developing and developed) countries have completed at least one NHA. Many of those countries have completed multiple rounds of NHA and the results of the exercise have been critical for informing policy. Some of the examples of the use in the region have been summarized below.

Bangladesh and Sri Lanka: Used NHA for Comparative Equity Analyses (summarized from Maeda et al. 2012). Data from NHA exercises conducted in both Bangladesh and Sri Lanka reveal that the health systems in these two countries are predominantly financed by taxes and out-of-pocket payments by households. NHA data along with household survey data have been used to assess the equity in the distribution of financing and health system resources. A comparative analysis revealed that – despite similarities in financing and delivery of services – there are significant differences in equity in the health systems; Sri Lanka's financing was found to be pro-poor whereas in Bangladesh, the distribution of health expenditures was not pro-poor. These findings have important implications for the development of pro-poor policies affecting the progressivity of health financing and the catastrophic impact of health financing.

Thailand: NHA data Informs Universal Coverage(summarized from Maeda et al. 2012) NHA exercises in Thailand have been used to inform the government's aims to promote universal coverage and to ensure the long-term fiscal sustainability of the health sector. NHA data has been used to estimate long-term projections of health spending, disaggregated by major cost drivers like age category and geographic region. In 1994, NHA data revealed high proportion of household out-of-pocket payments, representing 45 percent of total health financing. The projections revealed that a large proportion of the population remained uninsured and that households continued to bear a large burden of their health expenditures out-of-pocket. These findings led to the development of the Universal Coverage (UC) scheme in 2002. The UC scheme extended coverage to those who were previously uninsured, covering over 75 percent of the population. As a result, in 2008, NHA data revealed that households only account for 18 percent of total health expenditure.

NHA data informs cross-country comparisons for reproductive health services (summarized from Maeda et al. 2012). NHA data were used in a multi-country study on the costs and financing of reproductive health (RH) services in South Asia. Study sites were Bangladesh, Nepal, Pakistan, Sri Lanka, and the Indian states of Rajasthan and Andhra Pradesh. NHA data disaggregated RH expenditures by governments, donors, and households. The findings revealed wide variation in public-private health financing mix by country: public spending on RH ranged from 15–16 percent (Rajasthan and Sri Lanka) to 42 percent (Andhra Pradesh).

Financing for specific RH services varied widely by country – countries with similar income per capita exhibited strong variations in access to care. For example, while Bangladesh, Nepal, and Sri Lanka have similar RH expenditures in relation to GDP, Sri Lanka provides universal access to RH services, while Bangladesh and Nepal have less than one-half and one-third the levels of access, respectively.

While this variation may be attributed to differences in technical efficiency of public sector services across countries, these examples highlight the value of adopting international standards, harmonizing data (under the SHA), and producing comparable reports on health financing to facilitate international comparisons.

In India, responsibility for allocating resources, designing strategies, and implementing programs for health rest with the State (Garg 1998). Therefore, it is imperative to conduct SLHAs to track health spending at the state level. At this level, Punjab and Karnataka conducted SLHA exercises in 1999 and 2000, followed by Andhra Pradesh in 2004.

The 2000 Karnataka SLHA revealed that household out-of-pocket expenditures are high, accounting for 64 percent of the state's total health expenditure (Annigeri 2010). In addition, Karnataka did a breakdown of spending on reproductive health that indicated wide variation among districts with the majority of districts significantly trailing the high-performing districts (UNFPA, UNAIDS, NIDI n.d.).

Findings have been used to inform key parliamentary debates resulting in programs to improve people's financial access to care. Data from the first-round NHA coupled with the NCMH's disaggregated estimates were a vital ingredient in advocacy for and establishment of the National Rural Health Mission, whose objectives are mobilizing additional public

expenditure for health, revisiting the infrastructure distribution, pooling resources, and so forth (Maeda et al. 2012).

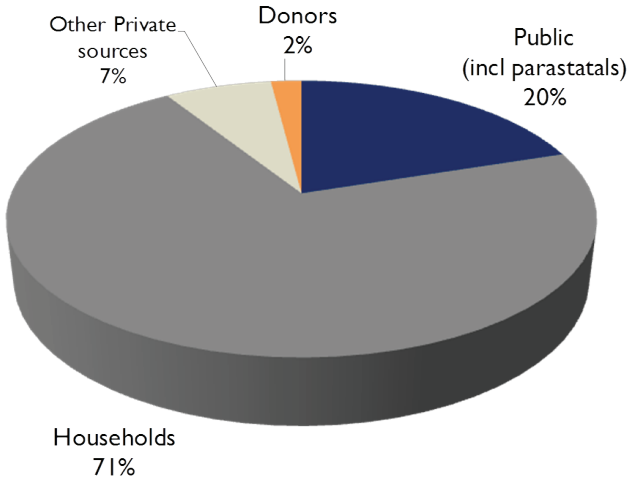
Institutionalization of Health Accounts

Though many lower- and middle-income countries have conducted a single NHA estimation to analyze their health expenditures, relatively few countries produce them regularly. Producing NHA on a routine basis is important to ensure that the health expenditure information remains up-to-date and relevant to policy discussions. It allows for more powerful analyses, as data over time illuminate trends in health spending, and make for more meaningful application of results, as more stakeholders will be aware of the results and how to use them effectively. Producing NHA on a routine basis can also result in higher quality data, as the systems for gathering needed inputs and the technical capacity of the NHA team will improve with each round of estimations. The process of establishing NHA as an integral and sustained part of government operations is called "NHA Institutionalization."

As noted above, India established an NHA Cell during its first round of NHA. The cell was placed within the MoHFW Bureau of Planning under the supervision of the Economic Advisor. These initial steps toward NHA institutionalization were supported technically and financially by the WHO India Office. In addition, a high-level steering committee was formed to guide NHA estimations and facilitate application of findings to policy concerns. It is chaired by the Secretary of Health and Family Welfare; secretaries from related departments sit on the committee. For the first two rounds, the NHA Cell carried out most of the data collection activities. Some data collection on health expenditures by NGOs, corporate firms, and local bodies was outsourced to research agencies (Rout 2012).

At the state level, Karnataka has established a Health Financing Cell under the World Bank-supported Karnataka State Health Systems Development Project (KHSDRP)[3]. The cell has conducted one round of SLHA, for 2008/09 and 2009/10, preliminary findings of which were released in 2012; the cell is in the process of updating the findings. The cell is supervised by the KHSDRP Chief Finance Officer under the leadership of the Project Administrator (IAS officer) and with the support of three consultants who help with data gathering and analysis. The plan is to hand over the cell to the State Department of Health and Family Welfare for continuing of SLHA activities.

Figure 1. India's Sources of Health Financing 2004/05



While desirable, as noted from India's experience so far, institutionalizing NHA can be technically and politically complex for countries and can take many years before the proper technical and governance systems are in place. Several key lessons to institutionalization of NHA/SLHA in India have been identified in a case study developed by Maeda et al. 2012:

1. There is a need to raise awareness about the NHA and its importance in policymaking in order to garner support and financing for carrying out future NHA estimations, further institutionalizing the process.
2. The technical nature of the NHA/SLHA methodology means that staff need to be properly trained in the key concepts and methodologies.
3. There is a need to strengthen the linkages between NHA findings and their application to the country's health policymaking and achievement of health system strengthening goals.

[3] Discussion with Mr. J. Manjunath, former Chief Finance Officer, KHSDRP.



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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Abt Associates Inc.
www.abtassociates.com
4550 Montgomery Avenue,
Suite 800 North, Bethesda, MD 20814

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WHO in collaboration with country health accounts experts, USAID, World Bank and other partners have identified key characteristics of institutionalized resource tracking systems (Cogswell et al 2013):

- Officially mandated. The government recognizes the value of NHA estimations and provides an official mandate to conduct NHA estimations on a regular basis.
- Incorporated in budgets. NHA is incorporated as an item in the government's annual budget.
- Housed in-country. NHA is housed in a stable institution that will promote application of the results to policy. Traditional locations include: the Ministry of Health, the Ministry of Finance, a central statistical bureau, or a local university.
- Proper team capacity. The country NHA team has the capacity to plan, manage, and monitor the SHA estimation process.
- Stakeholders engaged. A wide group of stakeholders and steering committee members are actively engaged in the production, dissemination, and institutionalization processes relating to NHA.
- Systematic data collection. A systematic process for collecting necessary health expenditure data exists including, if possible, incorporating NHA household survey questions into existing national surveys.
- Coordination. Mechanisms are in place to coordinate NHA estimations with other stakeholders and resource tracking activities.
- Reporting of results. Results are analyzed, disseminated, and used by a wide range of stakeholders to inform relevant policy discussions and increase system transparency.

Though the process for institutionalizing NHA will also vary country by country, countries can still reference these key characteristics in order to strategize actionable plans for moving forward. In response to these challenges, strategies and tools have been developed to facilitate the process. Examples include the Health Accounts Production Tool, which streamlines the production process, and the Analysis Tool, which automates basic analysis of results.

The Ministry of Health and Family Welfare in collaboration with USAID is exploring the best routes to fully institutionalizing health accounts in the country and address the critical areas indicated above.

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