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Issue Paper on NHA

The National Health Accounts process in Mali

Content

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Executive Summary

National Health Accounts (NHA) is recognised as a valuable tool in policymaking and decision-making within the health sector. The method helps identifying the sources of funds, how the funds are channelled to providers, and for what functions the funds are used. NHA is of specific interest for developing countries since these countries often face a considerable burden of disease and shortage of resources.

This paper gives a presentation of the process of the Mali NHA. Over the years there have been a few attempts to provide a comprehensive picture of the flow of funds within the Malian health sector. The first tentative NHA was developed in the 1980s and the second attempt, covering the years 1988-1991, was published in 1993. In 2002, a NHA feasibility study was conducted in Mali but no accounts were elaborated at that time. The structure of the health system in Mali has changed considerably since then. A private sector has emerged and an increased number of providers are now providing health care services.

In 2005, the first NHA study conducted according to international comparable methodology was initiated in Mali. A national research institute for public health is technically responsible for the current study. The data collection will be finalised before the end of year 2005 and a dissemination of results is scheduled for the first half of year 2006.

There are some challenges ahead for the NHA process in Mali. The first challenge is for the stakeholders in the health sector to interpret and actually use the results of the first round. The second challenge, connected to the first one, is the important issue of institutionalising the NHA process.

In order to facilitate the institutionalisation process, Mali is in need of support. For example, to be able to attend training workshops and participate in network activities financial support is needed. It is a strength for the institutionalisation process that Mali has former experiences and possesses local expertise in the production of NHA. The fact that the next demographic and health survey (DHS) in Mali will include a household health expenditure component will certainly have a positive effect in facilitating future NHA studies and the institutionalisation process. Further, the steering committee of the current study plays, and will play, a key role in assuring the institutionalisation in Mali. It will thus be of great interest to follow the development of the Malian health sector and see how the results from the NHA will be received by the steering committee and how the results will actually influence the policy making within the country.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CNS	Comptes Nationaux de la Santé National Health Accounts (NHA)
CPS	Cellule de la Planification et de Statistique Planning and statistical unit
CSC	Centre de Santé de Cercle
CSCOM	Centre de Santé Communautaire
EDSM	Enquête Demographique et de Santé au Mali Demographic and Health Survey (DHS)
EU	European Union
FA	Francophone Africa
FCFA	Franc Communauté Financière Africaine
HIV	Human Immunodeficiency Virus
IHE	The Swedish Institute for Health Economics
INRSP	Institut National de Recherche en Santé Publique
MoH	Ministry of Health
NGO	Nongovernmental Organisation
NHA	National Health Accounts
PDDSS	Plan Décennal de Développement Sanitaire et Social
PHRplus	Partners for Health Reformplus
PRODESS	Programme de Développement Sanitaire et Social
Sida	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

1. Background

Many developing countries face a considerable burden of disease together with a shortage of resources. These countries need to improve their health systems and the use of resources to better meet the necessities of the population. Improving health systems and making appropriate allocation decisions require reliable and current data on financing as well as complementary non-financial information. One internationally recognised tool intended to give a full picture of the expenditures on health is National Health Accounts (NHA). NHA provides information of the flow of funds within the health sector. It identifies the sources of funds, how the funds are channelled to the providers, and for what functions the funds are used. Currently, about 80 countries around the world have produced NHA at least once and approximately 60 of them are low- and middle-income countries.

In January 2003, the concept of NHA was formally launched in Central and West Africa at a meeting in Dakar, Senegal. At that meeting, the Francophone West and Central African Regional NHA Network (FA) was established in order to facilitate the exchange of information and experiences between the countries. The FA network includes around 25 countries.[1] In October 2003, a first regional NHA technical training workshop was held in Dakar where 12 countries, including Mali, were represented.[2] In Mali, there was an early interest in exploring the financing of the health sector, i.e. in the late 1980's the first tentative NHA was elaborated. After a second attempt in the beginning of 1990's the first NHA produced according to international comparable methodology was commenced in 2005. In January-February 2004 the Swedish Institute for Health Economics (IHE) conducted a study on the status of NHA and the use of health expenditure data in Mali (Glenngård and Hjalte, 2004). The current report is a follow-up of the study from 2004.

1.1. Objectives and Method

This paper mainly focuses on the ongoing NHA process in Mali. The objective of the paper is to present the procedure, the objectives and the expectations with NHA in Mali. First, a presentation of the current

[1] The FA countries include Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Madagascar, Mali, Niger, Rwanda, Senegal, Togo, Algeria, Burundi, Central African Republic, Comoros, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea, Guinea Bissau, Mauritania, São Tomé and Principe and Seychelles.

[2] The other participating countries were Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Madagascar, Niger, Rwanda, Senegal and Togo.

situation of the Malian health sector is given. Secondly, a brief overview of the NHA process in the country is presented. This is followed by a description of the characteristics of the current NHA round, the objectives and the expectations. The paper is ended by a discussion and some concluding remarks.

The study is based on interviews conducted with different stakeholders in the Malian health sector. The interviews were semi structured and took place in Bamako in November 2005. Respondents were selected based on the identification of respondents for the study in 2004 and according to their current managing position in the health sector and/or their involvement in the Malian NHA process. The respondents included representatives from the Ministry of Health (MoH), national research institute in public health, WHO, Sida, USAID, and Netherlands.

2. Overview of the Malian Health Sector

Mali is situated in West Africa and the country is composed of 8 regions plus the district of Bamako, the capital city. Mali is one of the world's poorest; rated 174 of 177 according to the UNDP Human Development Index, 2004. The development indicators are very poor; in 2003, life expectancy at birth was 40.6 years, infant mortality was 122 per 1,000 live births and fertility rate was 6.4 children per woman (World Development Indicators 2004). Malaria and other preventive diseases are the main causes of illness and death in Mali. A large part of the diseases origins from poor environmental conditions with lack of clean water and appropriate waste disposals. Respiratory infections, diarrhoea, malaria and malnutrition are the most important health problems among children. Mali's HIV/AIDS prevalence is low, i.e. 1.7 percent, in relation to the rest of Sub-Saharan Africa (Demographic and Health Survey-2001). As in many countries in the region, corruption continues to be an extensive problem in the Malian public administration.[3]

The first health sector reform in Mali (*Politique Sectorielle de Santé et de Population*) started in 1990. Since then, Mali has focused on primary health care and local participation according to the Bamako Initiative.[4] The goal has been to achieve financial participation by the citizens and to provide a minimum package of health care for the whole population. In 1997 the Ministry of Health (MoH) developed a health and social plan for 10 years, *PDDSS* (*Plan Décennal de Développement Socio Sanitaire)*, which covers the years 1998-2007.[5] The implementation of this ten-year national strategy for development of the health and social sectors is, however, delayed. The first five-year implementation plan covered the years 1998-2002 (extended to 2004), i.e. the *PRODESS* I (*Programme de Développement Sanitaire et Social*). The second five-year plan of the *PDDSS* is described in the *PRODESS* II and covers the years 2005–2009 (*PRODESS* II, 2004). In 2004, the

[3] According to the latest report by Transparency International (2005) Mali received a Corruption Perceptions Index (CPI) score of 2.9 (on a scale where 10=highly clean and 0=highly corrupt).

[4] The Bamako Initiative was a new health strategy based on community participation, adopted by African Ministries of Health in 1987. A central component within the initiative was to make essential drugs available to the main part of the population.

[5] The objectives with the plan are to decrease the prevalence and mortality of the main diseases, increase both the financial and geographical availability of health care services, fight the social exclusion of the health care services, increase the social mobilisation for health, develop alternative forms of health care financing, and develop the skills of the health care staff

Minister of Health in Mali changed, which was viewed as an important step for improvement of the management of the health sector (Sida, 2005).

Bilateral donors and multilateral organisations are important financing sources in the Malian health sector. Large multilateral organisations giving support are the World Bank (WB), the World Health Organization (WHO), the European Union (EU) and the United Nations Children Fund (UNICEF). Large bilateral donors are: the USA, the Netherlands, France and Canada. Most of these cooperating partners are giving support under the sector-wide approach (SWAp). Further, there are several Nongovernmental organisations (NGOs) working in the Malian health sector. Since 1992 there is an umbrella organisation for national NGOs, with some international partners as well, called *Groupe Pivot de Santé et Population* (GPSP). This organisation is working with competence building for its members and strengthening the cooperation between the NGOs and the MoH. Besides these sources of funds the households account for a significant part of the health care expenditures in the country.

Health care is mainly publicly provided in Mali. After the independence in 1960 private health care was not allowed. Private providers were allowed again in 1985 but their extension is still rather restricted and they are mostly found in the urban areas of the capital. Even though it is difficult to obtain any written documentation on the use of traditional medicine, this form of health care is extensively used in Mali. The wide variety of health care providers in Mali includes the following; public and para-statal health centres, private health centres, health centres belonging to enterprises or the military army, mutual and insurance companies, public and private health care schools, pharmacies, traditional therapists and NGOs.

At the lowest level of care in the public Malian health care system there are 674 community health centres (CSCOMs). These clinics provide a minimum package of health care. The district level includes 55 district health care centres (CSCs). The district health centres are primarily financed by public means and donors, supplemented by user fees. The hospital level is composed of 7 regional hospitals and 4 national hospitals. The MoH has a policy making and coordinating role in the system.

Three Demographic and Health Surveys (DHS) have been undertaken in Mali, the DHS-1987, DHS-1995/96 and the DHS-2001. They have been conducted by the Planning and Statistics Unit, CPS (Cellule de Planification et de Staistique), the National Directorate of Statistics and Computer Science, DNSI (Direction Nationale de la Statestique et de l´Informatique), with technical assistance from an Opinion Research Corporation company (ORC Macro). The data collection for the next DHS will start in the beginning of 2006. Compared to the previous DHS that did not include a component with household expenditures on health this next survey will include such a component.

3. Overview of the NHA Process in Mali

In Mali, NHA was on the agenda quite early compared to other countries in Sub-Saharan Africa. There have been two major efforts in exploring the financing of the Malian health sector. Both these attempts to create NHA in Mali have been undertaken by researchers at a national research institute for public health, i.e. the INRSP (*Institut National de Recherche en Santé Publique).* The first study, covering the years 1983 to 1987 was demanded by the WHO and financed by USAID (*Ministère de la Santé Publique et des Affaires Sociales* et al., 1989). The second study covered health expenditure data from the years 1988 to 1991 and was financially supported by UNICEF (Coulibaly and Keita, 1993).

The latter study, published in 1993, encountered a major problem in the data collection concerning household expenditures on health. In addition, the available information and documents at the MoH were rather limited. The bookkeeping and the financial management carried out by the MoH and the collection of health information was inappropriate and irregular, often including overestimated figures. All health care facilities were to be surveyed but because of the unstable political situation in the northern parts of the country it was not possible to cover all regions. The team attempted to collect all available data for the period 1988 to 1991 concerning the expenditures of recurrent activities and investments, the revenues, and the frequency of different services. However, some information was incomplete, some documents had disappeared, and some of the respondents were unwillingly to provide the requested information. Further, reluctance to provide information appeared to be a common problem within the private sector probably because of a suspicion of tax augmentations. When considering the private sector and its reporting and information systems, it was denoted as "total anarchy" (Coulibaly and Keita, 1993, p. 65). Total funds received from the government were known but the facilities were often unable to provide detailed information on their expenditures, why the team estimated expenditures for the periods where no actual data was available.

A major finding of the Mali 1988-91 NHA was the actual structure of the financing sources for health care in Mali. Prior to the study, this information was relatively unknown. The households accounted for a substantial part of the health expenditures, i.e. 75 percent, whereas the government accounted for 20 percent and the international sources including NGOs, bilateral donor organisations and international organi-

sations accounted for 5 percent. Since the main part of the Malian population lived below the poverty line the fact that the households accounted for such a significant part was a remarkable and striking result.

Further, the NHA report from 1993 concluded that, by that time, and with the poor quality of health expenditure data and information on health activities, no routine production of NHA would be possible in Mali. A main recommendation was therefore that the health care facilities first should establish health information systems and start using them. Then all information would be compiled and available at the central level and NHA could be developed at a reasonable cost.

According to the interviews the results from these two first studies of the expenditures on health in Mali have been widely used by the MoH in their organisation of funds for the health sector.

In the beginning of year 2000 the Malian MoH, with a highly concerned health minister, expressed a renewed interest in conducting NHA in Mali. In addition, cooperating partners demanded data in accordance with international formats and standards. Hence, a NHA feasibility study was carried out for investigating the health care financing in Mali (Keoula, 2002) and development of NHA was included in the operational program (activités opérationnelles) within the PRODESS for the years 2000 and 2001. The feasibility study aimed at clarifying potential problems with a NHA study and was financed by a research institute, l´Institut de Recherche pour le Développement (IRD)6. In 2002 when the report was finalised and was to be presented to the MoH the government changed and the involved staff at the MoH was replaced. This resulted in that no NHA was initiated in Mali.

After the NHA launching meeting in Dakar in January 2003, a budget for developing NHA was again incorporated in the operational plan for 2003. In October the same year representatives from Mali attended the first technical training workshop of the West and Central African Regional NHA network, which was held in Dakar.

[6] The IRD is a French public science and technology research institute under the joint authority of the French ministries in charge of research and overseas development. The research is focused on Mediterranean and tropical regions and has the objective of contributing to the sustainable development of these countries.

4. The Current NHA Study, 1999–2004

At present, a NHA study is under way in Mali, covering the years 1999 to 2004. The protocol for the study was finalised in March 2005 (Diakité et al., 2005). The timeframe for the study is ten months, from the launching of the study to the dissemination of the results. A draft report was supposed to be ready by the end of the year 2005 but it has been delayed. According to respondents, however, the results will probably be disseminated during the first half of 2006. The study is supported by the MoH, WB, WHO, EU, France, Netherlands, Canada and USAID. The budget for the Mali NHA is FCFA 76,995,000 [7], not including the sub-analysis.

The definition of health care activities used is in accordance with the definition in the OECD System of Health Accounts (SHA). The production of NHA tables will be undertaken according to the standard set of tables described in the NHA Producers Guide (WHO, 2003), i.e. Financing Sources (FS) X Financing Agents (HF), Financing Agents (HF) X Providers, Financing Agents (HF) X Functions (HC), Providers (HP) X Functions (HC). Two supplementary tables will be added for Mali. One is Financing Agents according to level in the health system and the other is Financing Agents according to poverty zone since the level of poverty differs across the country. [8]

There have been no NHA training workshops or meeting within the FA network since the ones held in Dakar, Senegal 2003. However, in December 2005 the *Centre Africain d´Etudes Supérieures en Gestion* (CESAG) organised a NHA training seminar in Dakar, Senegal. Unfortunately, no representatives from Mali participated due to lack of funding.

4.1. Objectives

According to the NHA protocol the specific objectives with the current NHA in Mali are as follows:

– To identify the different financing sources and their respective contribution in the health sector

[7] 1000 FCFA= 1.55 EUR, November 2005

[8] The country is divided into three zones of poverty; Zone 1: *Very poor* - includes 66 percent of the population in Mali and covers the regions of Mopti, Koulikoro, Ségou and Sikasso. Zone 2: *Average poor*- covers 21 percent of the population and the regions of Kayes, Tombouctou, Gao and Kidal. Zone 3: *Less poor*- is composed of the district of Bamako with 13 percent of the population (PRODESS II, 2004).

– To describe the evolution of health expenditures over time and understand its fluctuations
– To measure the government health expenditure per capita
– To institutionalise the production of NHA in Mali.

4.2. Steering committee and the NHA technical team

The NHA process in Mali is lead by a steering committee (*comité de pilotage*), composed of representatives from the different departments of the MoH, the cooperating partners (WHO, EU, WB, France, the Netherlands, USAID) and the INRSP. The cooperating partners included in the steering committee provide funding for the study. Further, a technical team, composed of researchers at the national research institute (i.e. INRSP), is responsible for conducting the accounts. Two external consultants are supporting the technical team and will regularly come to Mali in order to support and critically assess their work. The steering committee has a validating role in the elaboration and is commissioned to give feedback and resolve problems encountered by the technical team. It is worth noting that the steering committee plays a key role in assuring the institutionalisation of the production of NHA given that it is composed of policymakers in the health sector.

4.3. Data

The data collection for the current NHA includes both primary and secondary data collection. The collection of primary data regarding allocation and utilisation of funds is conducted through distribution of questionnaires. Six different questionnaires have been constructed, i.e. questionnaires for Financing sources, Financing Agents, Providers, Non-governmental organisations, Central Services and Insurance companies. The collection of secondary data consists of reviewing documents and existing, recently collected data. This will form the base for the estimation of the household expenditures. Institutional data is collected for the years 1999 to 2004 while the household data only will be estimated for 2004.

In the two earlier studies, performed in the late 1980´s and beginning of the 1990´s, the sample fully covered the central and district levels in all regions in the country but the northern ones due to safety reasons. Since the beginning of the 1990´s, the health system in Mali has, however, changed considerably and a private sector has emerged. The number of providers that is now providing health care services has significantly increased. Today, there are approximately 700 CSCOMs while in 1990 there was only one. Further, in 1990 there was only one *mutuelle* (mutual insurance company) and now there are at least 40. The number of pharmacies have also increased from only a few concentrated to Bamako in the beginning of the 1990´s to a current number of around 300 being spread all over the country.

At the central level the current NHA will investigate all the central structures, i.e. the public, para-statal and all the multilateral and bilateral donor organisations. At regional level all regional offices will be investigated as well as the regional hospitals. The functioning at the district level can differ between the districts. In order to capture these differences three district health care centres (CSC) in the district of Bamako and three in each region will be investigated, i.e. 27 out of 55 (50 percent). Further, three community health care centres (CSCOM) in each district, i.e. in total 90 out of 674 (14 percent) will be investigated. Note that for accessibility and security reasons some of the CSCOM in

the rural parts of the northern regions will not be investigated. When it comes to private pharmacies 28 percent will be investigated. Around 50 percent of the cabinet privées will be investigated and 50 percent of the private clinics.

In total, 24 persons have been selected, all with a university diploma, to work with the collection of data. These persons received training in NHA and are divided into teams, each with one supervisor responsible for the work. One team will cover two regions on average. The collected data will be registered by two teams simultaneously and then compared as to identify and minimise errors.

4.4. Expected results

The expected results of the current NHA, as described in the protocol, are presented below.

- Activity indicators (e.g. the number of consultancies and hospitalisation per person and year)
- The distribution of health expenditures between the different financing sources
- A partition of the health expenditures between recurrent costs and investments
- The distribution of health expenditures between regions and between the different levels in the health system
- The public, private and external parts of the total health expenditures and their development over time
- The share of the general state budget that goes to health care and its development over time

The NHA database will be published at the MoH website. Further, the results and the reports produced will be used in the work of the technical follow-up committee of the *PRODESS*. Decisions on resource allocation will be made based on the results from the NHA.

4.5. Sub-analysis

Three possible sub-analysis for Mali were identified by the INRSP, i.e. Malaria, HIV/AIDS and Reproductive Health. Only one sub-analysis is feasible to do at a time and thus the steering committee had to choose one of them. When deciding on which sub-analysis to choose one important difference between the three was identified, i.e. data collection from households. Both for the malaria and HIV/AIDS there are already studies on household expenditures, but there is nothing on reproductive health. Thus, a sub-analysis for the latter would require an additional study while for the other two the work with data collection would be less comprehensive. The following budgets for the general NHA plus sub-analysis have been estimated:

HIV/AIDS: CFA 100,295,000

Malaria: CFA 100,295,000

Reproductive Health: CFA 119,795,000

Due to the already existing data on malaria in Mali the sub-analysis for malaria was selected. The collection of data for the sub-analysis will be based on the study on the costs of malaria produced by the INRSP in 2004 (Keita et al., 2004).

5. Discussion and Concluding Remarks

Over the years there have been several attempts to capture the scope and characteristics of the health expenditures in Mali. The first attempt in the late 1980s indicated an early interest and understanding of the importance of a tool like NHA. There is at present an ongoing NHA study in Mali. The accounts are conducted according to international recognised methodology, which will make the results from the study comparable with results from other countries. The study is supposed to be finalised and disseminated during the first half of 2006.

It is more than ten years since the last study on health expenditures was conducted in Mali. The future regularity of producing NHA has not been specified either in the protocol or by the respondents in this study. Elaborating NHA requires substantial human resources and the fact that Mali is a vast country makes the data collection even more complex. According to some of the interviews future NHA studies would probably be as resource demanding as the current one. The fact that the next DHS will include a household health expenditure component will, however, certainly facilitate future NHA studies in Mali. This means that no separate data collection for the households' expenditures will be needed. As a result the institutionalisation process of NHA in Mali could be easier.

It remains to be seen what results will come out from the current study and especially how these results will be used for policy purposes in Mali. The next challenge for the stakeholders in the health sector will be to interpret and actually use the results. When stakeholders are appreciating the benefits of using the accounts they will demand regularly updated information. This is highly related to the second challenge, i.e. the issue of institutionalisation. Evidence from other studies show that institutionalisation of NHA requires a committed government that uses the results of the accounts (Hjortsberg, 2001; De et al, 2003).

It is a strength for the institutionalisation process that Mali possesses local expertise in the production of NHA. The same staff and local research institute that were responsible for the former studies undertake the current one.

Mali is in need of at least financial support in order to be able to institutionalise NHA. As an example, no one from the country could attend the regional training workshop in Senegal in 2005 due to lack of funding. Nevertheless, it would have been essential for Mali to send representatives to the training workshop since a round of NHA is cur-

rently underway. Being a member of the Francophone Africa NHA network it is important to meet with other members in the network in order to share experiences and problems of the NHA implementation and to create contacts for future collaboration.

When it comes to the important issue of ownership of the NHA, the steering committee plays and will play a key role in assuring the institutionalisation of the production of NHA in Mali. The steering committee is composed of policymakers and cooperating partners in the health sector and is lead by the MoH. The committee makes all decisions and validations within the NHA process. It will thus be of great interest to follow the development in the Malian health sector and find out how the results from the accounts will be received by the steering committee and if and how the results will actually influence the policy making within the country in the future.

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