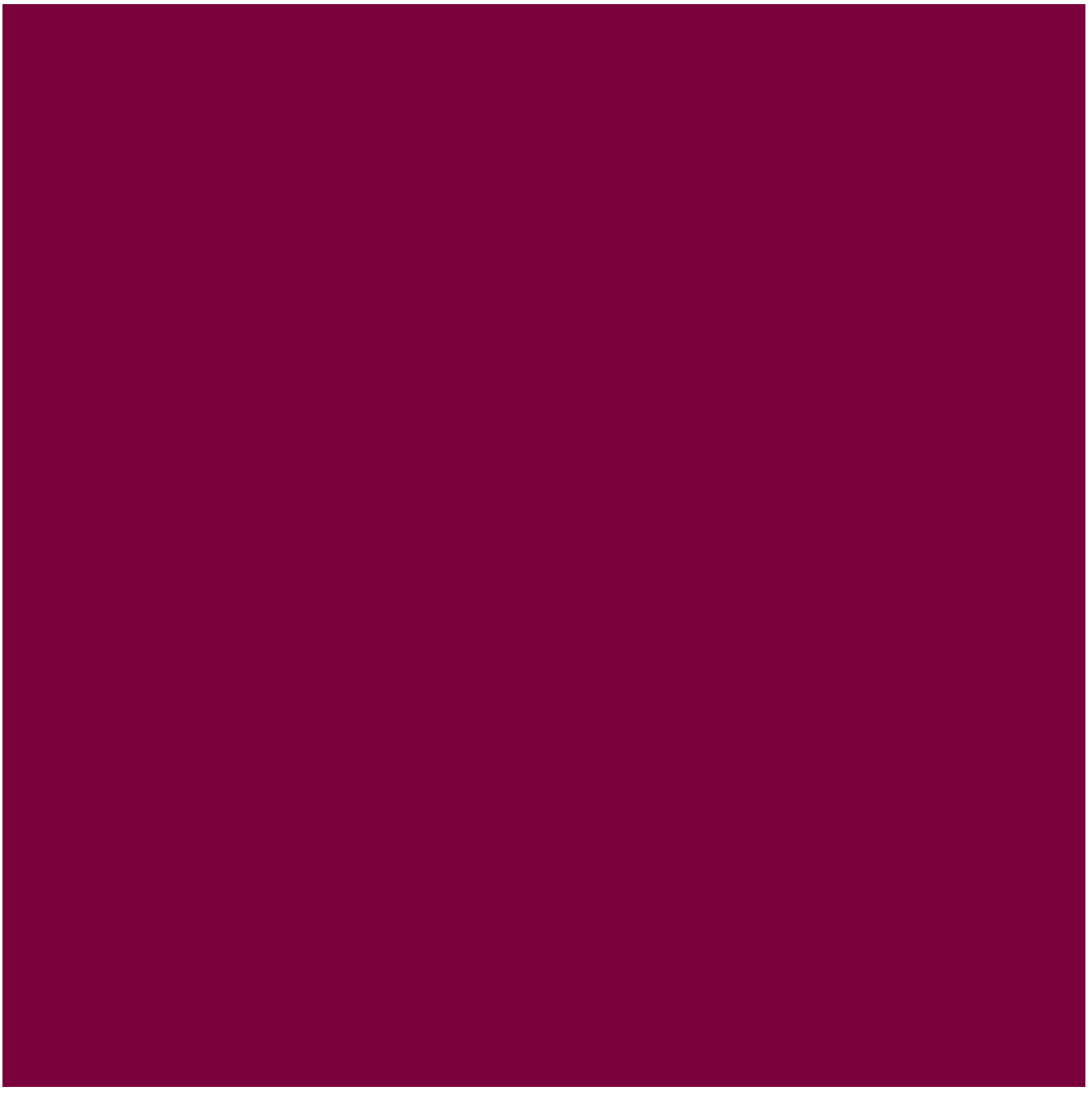
JUNE 2007 • HEALTH DIVISION

What factors determine the demand for health expenditure data in Sub-Saharan Africa?



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Abbreviations

DHS	Demographic and Health Survey
GDP	Gross Domestic Product
HMIS	Health Management Information System
MDGs	Millennium Development Goals
MTEF	Medium Term Expenditure Framework
MoH	Ministry of Health
NHA	National Health Accounts
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Surveys
Sida	Swedish International Development Cooperation Agency
SSA	Sub-Saharan Africa
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

1. Background

Sub-Saharan Africa (SSA) is the poorest region in the world including many of the least developed countries in the world. Public health care in this region has gone through a long period of increasing shortage of resources for health. Important problems of public health systems in countries in SSA are services of poor quality, inequitable distribution of resources and services, and inefficient supervision coupled with a high disease burden (WHO 2001; Streefland 2005; Gauri 2001).

The Bamako Initiative is an initiative adopted by African health ministers in 1987 that helped reform the health policy of SSA. The initiative was promoted by UNICEF and WHO and aimed at increasing the availability of resources for essential drugs. Health decision-making was proposed to be decentralised to the district level. Establishing a national drug policy and providing basic essential drugs were also important issues in the initiative. Community participation in the financing of the health services was a key word in the initiative adopted by the African health ministers. Another health policy target was adopted in 2001, in Abuja, Nigeria, whereby African leaders adopted the goal that the proportion of expenditures on health as a share of total government spending should be 15 percent. Besides these initiatives, many countries in the region have developed national strategic plans for the health sector aiming at providing accessible and affordable health care services to their entire populations.

Implementing policies or priorities in the context of health systems is difficult just as in any other resource scarce environment. Scarce resources for health make it in practice difficult for policy makers to prioritise one area without cutting from other areas. High quality data on health expenditures is needed for e.g. priority setting, monitoring and evaluation of the use of funds in the health sector. Some countries in Sub-Saharan Africa have successfully developed and used health expenditure data while others have not. Much can be learned from the OECD experience that shows how high quality data can generate demand for increased use for policy purposes. National Health Accounts (NHA)[1] are designed to help policy makers in their efforts of improving health systems. When creating demand for NHA and other health expenditure

[1] NHA is an internationally recognised tool providing information about a countrySection 1 s total expenditure on health. Expenditures are organised in a set of tables that in a comprehensive manner gives a picture of the flow of funds within the health sector, i.e. the sources of funds, how the funds are channelled, and how the funds are finally being utilised, irrespective of who is paying.

data it is important to demonstrate its usefulness and analytical capacity in both health financing policy and strategic planning. Evidence show that political will to use and produce NHA can be found in several countries that have succeeded in institutionalisation of NHA. If the government is using the results for policy purposes NHA are likely to be produced on a regular basis in order to provide decision makers with accurate and up-dated information to support decision-making (Hjortsberg 2001; De, Dmytraczenko et al. 2003).

1.1 Objective

The objective of this study is to map the local use and demand for health expenditure data and identify what factors determine the demand for health expenditure data in countries in Sub-Saharan Africa.

1.2 Methods and Data

Two sources of data were used, i.e. questionnaires (see Appendix A) and a review of relevant documents and literature. The questionnaires (developed in collaboration with WHO, Geneva) were sent by e-mail to country representatives at e.g. Ministries of Health (MoH), local institutes and local World Bank (WB) and World Health Organization (WHO) offices. The criteria used for choosing countries were Sub-Saharan countries having conducted at least one round of NHA. Two reminders were sent with two-week intervals to those who did not respond.

1.3 Disposition of report

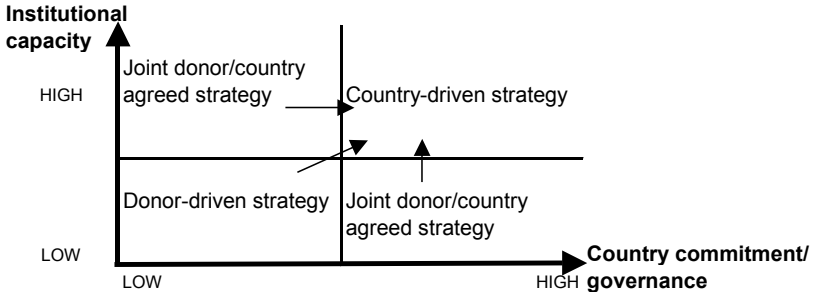
In the next chapter, a brief description of the characteristics of supply-driven versus demand-driven approaches to capacity building is given. Next, the results from the study, focusing mainly on the current use of and demand for health expenditure data, the importance and availability of health expenditure data, and problems, limitations and incentives for using health expenditure data are presented. The report is ended with a discussion and concluding remarks.

2. Demand for information and organisational motivation

In developing countries there has often been a supply-side, donor-driven approach of capacity building but there is an emerging consensus that this has to be shifted to a demand-led process (Govindan, 2003). This applies also to the development and use of NHA and other health expenditure data. Previous studies show that the main users of NHA appear to be donor agencies and multilateral organisations (Hjortsberg 2001; De, Dmytraczenko et al. 2003). For donors it is important to accurately determine how the additional funds provided are used so that these do not replace nor reduce other sources of funding, i.e. to avoid crowding-out effects. In a recent study it was also shown that the use of health expenditure data is highly relevant for purpose of monitoring and evaluating Global Health Initiatives activities (Hjalte and Hjortsberg, 2007).

According to Govindan (Govindan, 2003), in-country capacity development has to stem from not only acquisition of skills but also from utilization and retention of skills. Moreover the recipient country has to be in the "driver's seat" and own the development strategy. However, where governance is weak or institutional capacity is poor development partners may have to be a part of the strategy rather than let the country fully lead the process (see Figure 1).

Figure 1. Supply-driven versus demand-driven development strategy



Source: Govindan, 2003

Institutional capacity or capabilities is a prerequisite for change but also the willingness or incentives to actually utilise existing capacity is needed. Franco et al (2002), define two important components in the motivational process of an organisation. First, the extent to which resources including skills are mobilised to enable the achievement of organisational

goals – that is the "can-do" or capacity component. Second, the extent to which human resources adopts those goals – that is the "will-do" or the willingness component. Motivation in the work context can be influenced through four different channels (Franco et al., 2002):

- Through efforts to improve working capability.
- Through provision of resources and processes.
- Through feedback or consequences related to job performance.
- Through more indirect aspects such as work culture.

Capacities or capabilities are influenced by recruitment processes that ensure a close match between skills and functions and continuous training and feedback on performance, i.e. factors that are possible to control and/or measure to a high extent. The willingness component is, however, affected by factors less easily controlled or monitored such as awareness of the organisations goals and through incentives in the form of salaries, bonuses and training opportunities, thus primarily through feedback related to job performance and work culture (Franco et al., 2002; Rigoli and Dussault, 2003).

3. Use of and demand for health expenditure data in Sub-Saharan Africa

This section is based on information collected through a questionnaire sent out to country representatives at MoH, other local institutions and local WB and WHO offices. Questionnaires were sent by e-mail to one or more representatives in 36 countries in Sub-Saharan Africa.

3.1 Respondents

Identifying and receiving answers from respondents turned out to be a somewhat difficult task, which also resulted in lower response rate than expected. In total, 26 respondents from 18 countries are represented in the study (see Table 1). The majority of the respondents (16 respondents) worked for the MoH in their respective countries. Other organisations and institutions represented are WHO, the WB and universities. The countries represented in the study differ in terms of how far they have come in the process of institutionalisation of NHA. In some of the countries the NHA process is regarded as fully institutionalised whereas in other countries the process has recently started.

Table 1. Countries represented in the study and the countries' status of NHA.

Country	Frequency	Level of institutionalisation of NHA [2]
Benin	1	Completed 1 round for 2003. Planned next.
Botswana	1	Draft NHA just completed covering 2000-02. Intention to do another for 2004–06.
Cameroon	1	First round will be carried out from May 2007.
Congo	1	No NHA
Ghana	2	Completed 1 round for 2002.
Kenya	2	Institutionalised
Madagascar	2	First NHA produced in 2005 for the year 2003.
Malawi	1	Completed 1 round for 1998/99.
Mali	2	Completed 1 round covering 1999–2004
Mauritius	1	Completed 2 rounds. Last round cover 2003/04
Mozambique	2	Last round in 1997
Niger	1	Completed 2 rounds; 2003 and 2004. Preparing a 3rd round.
Nigeria	2	Completed 1 round for 1998–2002, yet to be disseminated.

[2] This information was not obtained from the questionnaires (except for Botswana, Cameroon, Congo, Madagascar, Mauritius and Mozambique who mentioned the status in the questionnaire). IHE is routinely collecting information about the status of NHA worldwide. Please note that we might not have the most recent information for all countries.

Country	Frequency	Level of institutionalisation of NHA
Rwanda	1	Institutionalised
South Africa	1	Completed more than one round but not on regular basis
Tanzania	2	Completed 1 round covering 1999/2000
Uganda	1	Completed 2 rounds; 1997/98 and 1998/99–2000/01. Preparing a 3rd round.
Zambia	2	Institutionalised
Total	**26**	

3.2 Current use of health expenditure data

All respondents considered it relevant to use health expenditure data in their respective organisations. Fifty percent of the respondents rated the relevance as 'Very High'. None rated the relevance as 'Low' or 'Very Low'. The respondents were asked to what extent different sources of data were used for *setting priorities* regarding the allocation of resources for health, for monitoring the implementation of health policies and use of resources for health and for evaluating implemented health policies or programs in the health sector. In this study, setting priorities was defined as the phase *before implementation*, monitoring as the phase *during implementation*, and evaluating was defined as the phase *after implementation* of policies or programmes. In table 2, the proportion of respondents using Demographic and Health Surveys (DHS), National Health Accounts (NHA), Public Expenditure Reviews (PER) and Medium Term Expenditure Frameworks (MTEF) for the different purposes is presented. Other sources of data used that were added by the respondents were e.g. national strategic plans and findings from programme and system reviews, budget framework papers, Public Expenditure Tracking Surveys (PETS), quality of service delivery surveys, living standards measurement surveys, household surveys, and health information systems.

Table 2. Use of different sources of data for setting priorities and monitoring and evaluating health policies in the health sector (Proportion of respondents, %)[3].

	Use for setting priorities regarding the allocation of resources for health	Use for monitoring the implementation of health policies and use of resources for health	Use for evaluating implemented health policies or programs in the health sector
DHS	96	76	88
NHA	71	64	68
PER	80	81	81
MTEF	92	85	77

DHS seem to be more used for setting priorities and for evaluating health policies than the other sources. This could be explained by the fact that there usually exists no supplementary information to DHS. DHS is the only source of demographic data whereas NHA, PER and MTEF contains information about health expenditures or other financial information. Compared to the other sources of data, the use of NHA when setting priorities and monitoring and evaluating health policies seems to

[3] The respondents were asked to rate the extent of use between 1 and 5 where 1=Not at all and 5= Very much. In this presentation the proportion of respondents who answered 3-5 (i.e. defined as use) are shown.

be in general lower. However, all of the respondents were familiar with the concept of NHA and approximately 75 percent (20 respondents) state that they use NHA within their respective organisations. The remaining part stated that they do not use NHA within their activities. Mentioned areas of use of NHA were for analysing the expenditures for health in order to set priorities regarding budgeting and policy formulation and to monitor health budget allocations. Other areas of use were for making comparisons with other countries and for serving as a basis when negotiating budget allocations with MoF and donor agencies. The primarily reason given for not using NHA was that the NHA is not yet available for use but there is an interest for using it.

3.3 Current demand for health expenditure data

The respondents were asked to list five indicators that that they would like to track for health expenditures under their respective organisation. At least two indicators were listed by 21 of the 26 respondents (see Appendix B). Information about total health expenditures, either in absolute terms or per capita or as a percentage of GDP, was the most frequently mentioned indicator. Also information about sources of funding, especially government and household expenditure on health as a percentage of total government spending or as a percentage of total health expenditures, was frequently mentioned. Besides these indicators relating to total health expenditures the respondents requested indicators at a more disaggregated level relating to income or geographical distribution among the population or different health care functions.

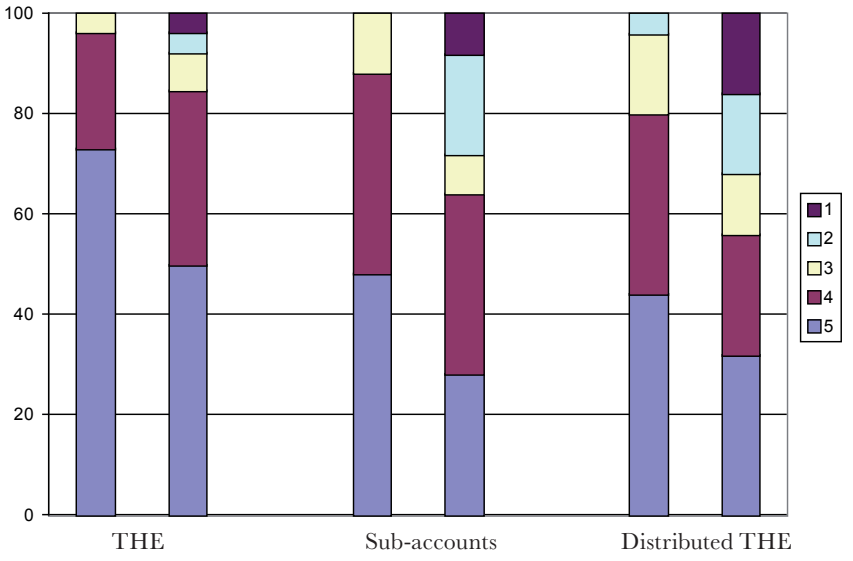
The responses from the questionnaires indicate that besides the available data there is an interest and a need for more disaggregated data and time-series data, e.g. expenditures by programme, disease (HIV, TB, Malaria) health intervention and service (preventive and curative care, reproductive health, drugs, human resources, medical supplies, non-medical supplies etc), provider type, or income quintile. There is also a need for vital statistics, household expenditure data, epidemiological data, and information from the Health Management Information System (HMIS) and Core Welfare Indicators.

3.4 Importance and availability of health expenditure data

In Figures 2 a-2 c the importance and availability of some of the aspects of the financial flow in the health sector, as rated by the respondents, are presented. It can be noted that the importance and relevance of using health expenditure data in general was considered higher than the actual availability of such data.

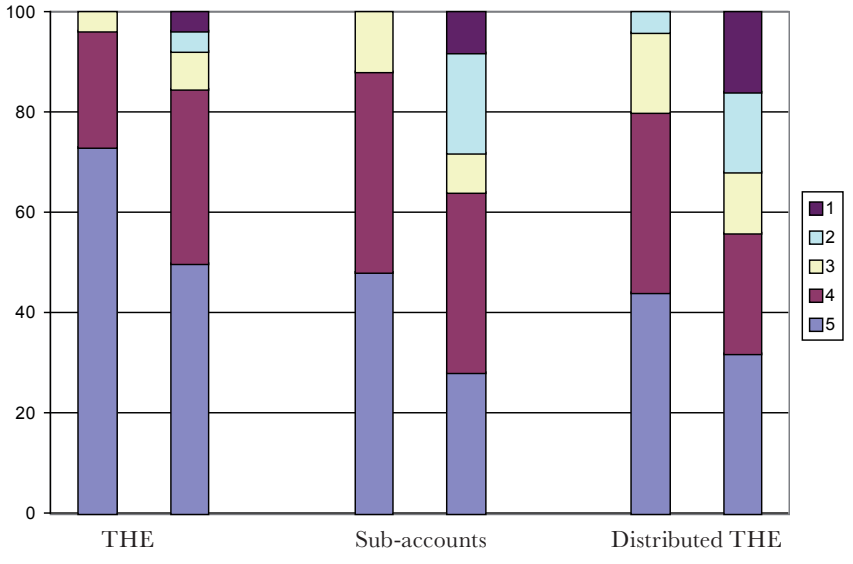
The importance of aggregated as well as disaggregated information about total health expenditures (THE) was considered high among the respondents. Information about aggregated total health expenditures was considered slightly more important than information generated by sub-accounts or distributed total health expenditures, e.g. by income quintile or age groups (Figure 2a). Regarding availability, however, the difference between aggregated and disaggregated data is greater where the availability of disaggregated data was considered lower.

Figure 2a. Importance (left column) and availability (right column) of *general data* regarding the financial flow in the health sector (1=not important/not available and 5=very important/high availability).



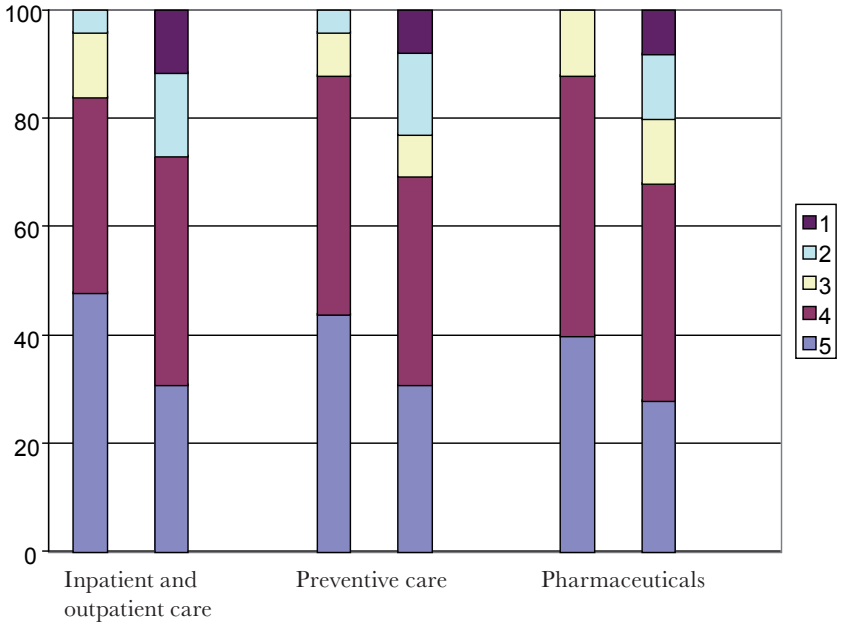
Regarding sources of funding in the health sector the respondents indicated that information about the governments spending is more important than information about spending by households and donor organisations. The availability of information was, however, regarded equally for donors and the government. The respondents regarded the data for households to be of the least importance as well as of the lowest availability (Figure 2b).

Figure 2b. Importance (left column) and availability (right column) of data regarding the *sources of funding* in the health sector (1=not important/not available and 5=very important/high availability).



Almost all respondents regarded expenditure data for health care functions to be of high importance. The availability of such data was considered to be slightly higher for pharmaceuticals than for preventive care and inpatient/outpatient care (Figure 2c).

Figure 2c. Importance (left column) and availability (right column) of data regarding the financial flow for *different health care functions* (1=not important/not available and 5=very important/high availability).



3.5 Problems and limitations when using health expenditure data

The respondents were asked to what extent various aspects of health expenditure data were considered as problems/limitations when using the data. The suggested aspects were availability of data, relevance of data, quality of data, format of data, timeliness of data and capacity to interpret and analyse data. The availability, the quality and the timeliness of data were considered as being a problem by most of the respondents, although to different extents. For example more than 50 percent thought that low availability of data is a big or a major problem. Comments regarding the availability are that organisations are unwilling to provide data and there is no system of collecting data routinely. A problem is also that there are not always resources available so that data can be collected. Further, there are many different data sources that are not consistent with each other as well as that the data available is not always disaggregated enough.

Regarding the quality and timeliness of the data standardisations of the data collection instruments is needed since the collection methods are sometimes inappropriate and too many. The NHA process takes too long to complete and it is a problem since much data come out with a significant lag. This is stated to be a result of infrastructural and logistical problems. Another comment is that there is no commitment to produce timely data.

Almost 75 percent perceived that the relevance of data was a problem when using health expenditure data in their respective organisation. A comment regarding the relevance is that sometimes the data collecting agencies do not consult the data users, which therefore results in a poor relevance of the data being produced.

More than 50 percent of the respondents believed that the format of data and the capacity to interpret and analyse data constituted a problem. A problem with the format is that there are many different reporting formats depending on programme. Problems with the capacity to

interpret and capacity to analyse data are explained by insufficient skills and training and that capacity development among stakeholders is needed.

3.6 Incentives for using health expenditure data

The respondents were asked to list five reasons/incentives or motivational factors for using health expenditure data in their respective organisation. All 26 respondents proposed a list of factors (see Appendix C). The most frequently listed reason was that it helps making evidence based decisions regarding allocation of health resources and helps support health policy formulations. Related to this it was also mentioned that it helps justify budget allocations in the health sector and increases transparency in spending. Anther reason was that the use of such data facilitates evaluation of strategies and provides an instrument for measuring achievements in the health sector against set targets, e.g. Millennium Development Goals (MDGs) or spending patterns. It was also mentioned that it facilitates comparisons of health systems across different countries.

4. Discussion

The demand for NHA and other health expenditure data is closely linked to the actual capacity to use such information within countries. In that way there is a close link between creating demand and developing in-country capacity. If there exists analytical capacity and an understanding of how to use the data, a demand for the information is naturally created. In the NHA Producers Guide institutionalisation is defined as "having an established organizational "home" and stable technical capacity to develop ongoing expenditure estimates" (WHO 2003). One very important factor within the institutionalisation process is the government's actual use of the accounts. Political will to use and produce NHA can be found in several countries that have succeeded in institutionalisation of NHA. If the government is using the results for policy purposes, accounts are likely to be produced on a regular basis in order to provide decision makers with accurate and up-dated information to support decision-making. Previous studies have revealed that the main users of NHA at the local level appear to be donor agencies and multilateral organisations although national policy makers gradually appreciate the benefits of using the information (Hjortsberg 2001; De, Dmytraczenko et al. 2003).

All respondents in the current study considered it relevant to use health expenditure data in their respective organisations. According to the results in this study, the importance and relevance of different data regarding the financial flow in the health sector was in general rated higher than the availability of the same type of data. All respondents were familiar with the concept of NHA and approximately three thirds stated that they use NHA within their respective organisations. NHA was mentioned to be used for analysing the expenditures for health in order to set priorities regarding budgeting and policy formulation and to monitor the health budget allocation. Other areas of use were for making comparisons with other countries and for serving as a basis when negotiating with MoF and donor agencies. Compared to other sources of data, e.g. DHS and MTEF, the use of NHA when setting priorities, monitoring and evaluating health policies is lower. The primarily reason given for not using NHA was that the information is not yet available for use but there is an interest for using it.

The demand and use of NHA and other health expenditure data at the local level is similar to that at the global level. At the global level, it was shown in a recent study that global health initiatives also consider it

highly relevant to use NHA and other health expenditure data and that they currently use such data for monitoring and evaluating purposes (Hjalte and Hjortsberg, 2007). The three main areas in which health accounts are used are for health system performance, for sub-analyses (e.g. disease specific) and for monitoring of projects. The use of health accounts was believed to have advantages in terms of showing spending on different health activities, tracking health expenditure trends, facilitating comparisons between countries and tracing use of funds. About one third of the health initiatives represented in that study find that the use of health accounts increases the transparency, contributes to efficient allocation of resources and identifies gaps for resource needs. According to that study, there is a strong demand at the global level to further disaggregate information into diseases, interventions and other more detailed categories i.e. socio-demographic and sub-national levels. Based on the results from the current study there is an interest and need, also at the local level, for more disaggregated data and time-series data, e.g. expenditure by programme, by disease, by health intervention and service, by provider type and by income quintile.

Reasons given for using health expenditure data, mentioned at both local and global levels, were that it facilitates evidence-based and efficient resource allocation and evaluation of strategies against set targets, enables for comparisons across countries and might lead to increased transparency. Although there is interest for using health expenditure data for policy reasons this does not automatically create a demand for such data. To stimulate the demand-side it is crucial to work with factors improving institutional motivation. Both capabilities and incentives for using information are required. It takes time to work with factors related to institutional motivation, especially the factors relating to incentives or the will-do component. Improvements of capabilities or the can-do component might be easier to achieve in the short term. This study indicates that low availability, poor quality and poor timeliness of health expenditure data as well as the format and capacity to interpret and analyse such data constituted problems in the use of health expenditure data for policy purposes in many countries. Improving the quality of health expenditure data would be one way of tackling the perceived problem of poor format and low capacity to interpret and analyse health expenditure data, thereby improving institutional capacity and stimulating the demand side for such information. Policy demand has previously been successfully generated by supply and use of high quality data in the OECD countries. It is, however, important to match the supply of data with the existing demand for data. As mentioned by some respondents in this report, sometimes the data collecting agencies do not consult the data users, resulting in a poor relevance of the data being produced.

5. Concluding remarks

This study reveals that the demand and use of NHA and other health expenditure data at the local level is similar to that at the global level. Both at local and global levels it is considered relevant to use health expenditure data to e.g. evaluate strategies against set targets, to make comparisons across countries and to increase transparency. There is also an interest and need for more disaggregated data at both the local and global levels.

In this study it was found that the importance and relevance of information regarding the financial flow in the health sector is rated as higher than the availability of the same type of data. Several factors that determine the local use and demand for health expenditure data were identified. Some factors are related to institutional motivation, including capabilities and incentives of using data, while other factors identified are related to the quality of data.

To shift a supply-side, donor-driven approach of capacity building in the health sector to a more demand-led process, the local demand for health expenditure data has to be further encouraged. In order to enhance the demand for health expenditure data it is important to work with factors related to institutional motivation. It takes time to work with these factors and institutional capabilities might be easier to influence in a short-term perspective compared to influencing incentives for using information. A possible future scenario of stimulating the demand-side is a long-term process of capacity building and following the OECD experience where policy demand has been generated by supply of high quality data.

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Appendix A.

Questionnaire for evaluating the demand of health expenditure data in countries in Sub-Saharan Africa

Questionnaire was sent to

Country :

Institution :

Person's position :

1. **How would you rate the <u>relevance of using</u> health expenditure data in your organisation?**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Very low Very high

2. **To what extents are the following sources of data currently used <u>for setting priorities regarding the allocation of resources for health</u> in your organisation? Please note that the given examples are optional. Add other sources as needed.**

	Not at all				**Very much**
1. Demographic and Health Survey (DHS)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. National Health Accounts (NHA)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Public Expenditure Review (PER)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Medium Term Expenditure Framework (MTEF)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Setting priorities refers to the phase ***before*** **implementation.**
Monitoring refers to the phase ***during*** **implementation**.

Evaluating ***refers to the phase*** after *implementation.*

3. **To what extents are the following sources of data currently used for <u>monitoring the implementation of health policies and use of resources for health</u> in your organisation? Please note that the given examples are optional. Add other sources as needed**

	Not at all				**Very much**
1. DHS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. NHA	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. PER	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. MTEF	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

4. **To what extents are the following sources of data currently used for <u>evaluating implemented health policies or programs in the health sector</u> in your organisation?**

	Not at all				**Very much**
1. DHS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. NHA	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. PER	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. MTEF	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. **What kind of additional data or sources of data are you interested in/ in need of for purpose of setting, monitoring and evaluating priorities and policies in the health sector in your country?**

6. How important is it for your organisation to have information about the following aspects of the financial flow in the health sector, and what do you use it for? (mark appropriate level for each aspect)

Data	Relevance Not important				Very important	Use
1. Total expenditure on health (THE)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
2. Subaccounts THE (e.g. Malaria, Reproductive Health) *Please specify which*:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
3. Distributed THE (e.g. by quintile, age group) *Please specify which*:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
4. Sources of funding	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Government	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Households	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Donors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Other : ☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5		
5. Financing Agents	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Government (central, subnational)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Public social insurances	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Expenditures by foreign organisations	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Households	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
e) Other : ☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5		
6. Health care providers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Hospitals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Ambulatory establishments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Traditional healers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Pharmacies	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
e) Other : ☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5		
7. Functions	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Inpatient / Outpatient care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Preventive care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Pharmaceuticals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Health administration	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
e) Other : ☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5		
8. Resource costs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Human resources	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Pharmaceuticals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Investments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Other : ☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5		

7. How would you <u>rate the availability</u> of information about the following aspects of the financial flow in the health sector? (mark appropriate level for each aspect)

Data	Relevance Not important				Very important	Use
1. Total expenditure on health (THE)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
2. Subaccounts THE (e.g. Malaria, Reproductive Health) *Please specify which*:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
3. Distributed THE (e.g. by quintile, age group) *Please specify which*:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
4. Sources of funding	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Government	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Households	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Donors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Other :	☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5	
5. Financing Agents	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Government (central, subnational)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Public social insurances	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Expenditures by foreign organisations	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Households	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
e) Other :	☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5	
6. Health care providers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Hospitals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Ambulatory establishments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Traditional healers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Pharmacies	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
e) Other :	☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5	
7. Functions	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Inpatient / Outpatient care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Preventive care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Pharmaceuticals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Health administration	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
e) Other :	☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5	
8. Resource costs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
a) Human resources	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
b) Pharmaceuticals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
c) Investments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
d) Other :	☐ 1 ☐ 1	☐ 2 ☐ 2	☐ 3 ☐ 3	☐ 4 ☐ 4	☐ 5 ☐ 5	

8. If, and when, using health expenditure data in your organisation, to what extent do the following aspects constitute a problem/limitation? (please mark appropriate level for each aspect and give a comment to your choice)

	No problem				Major problem
1. Availability of data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Relevance of data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Quality of data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Format of data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Timeliness of data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Capacity to interpret data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Capacity to analyse data Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Other (please specify) Comment:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. How would you rate the interest of using health expenditure data (e.g. National Health Accounts) in your organisation?

☐	☐	☐	☐	☐
1	2	3	4	5
Very low				Very high

10. Please list 5 reasons/incentives/motivational factors for using health expenditure data in your organisation

1.

2.

3.

4.

5.

11. Please list 5 important indicators that you would like to track for health expenditures under your organisation. (e.g. government expenditures on health as % of total government expenditures, proportion of total health expenditures on curative, preventive and promotive care, health expenditures on malaria or HIV/ AIDS as % of total health expenditures)

1.

2.

3.

4.

5.

12. Are you familiar with National Health Accounts (NHA)?

YES

NO

NHA measures total – public, private, and donor – national expenditure on health. NHA determines how much each financing agent spends on health care, and carefully tracks the *flow* of funds from one health care actor to another.

13. If yes, do you use NHA within your organisation?

YES, please specify in what way

NO, please specify why not
(e.g. of no interest, of interest but not available, of interest but not accessible, etc.)

14. Any additional comments?

If you have any questions about the study,
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Appendix B.

Answers from question 11

Please list 5 indictors that you would like to track for health expenditures under your organisation

1	1. Government expenditure on health
	2. % of GDP spent on health
	3. % health expenditure spent by households
	4. % government exp spent on private sector providers
2	1. Government expenditure on health as percentage of total government expenditure
	2. Primary health care expenditure as percentage of total health expenditure
	3. Health expenditures for poor families as percentage of total expenditures.
	4. Costs of preventive services compared to preventive services
	5. Geographical distribution of health expenditures
3	1. Government expenditure on health as a % of total health expenditure
	2. HHs expenditure on health as a % of total health spending
	3. Proportion of health expenditure attributed to preventive and curative
	4. Health expenditure on HIV/AIDS/Malaria/Reproductive health/Child health as a % of total health spending
	5. Donor spending on health as a % of total health spending
5	1.Government expenditures on health as % of total Government expenditures
	2. Health expenditure on Malaria as % of total health expenditure
	3. Health Expenditure on HIV/AIDS as % of total health expenditure
	4. Health expenditure on Reproductive health as % of total health expenditure
	5. Household expenditure on health as % of total health expenditure
6	1. % health budget
	2. Part from the major donors
	3. % investments
	4. % expenditures on health programmes
	5. % expenditures per level of care
7	1. Total state and LGA allocations for health (and as a % of the respective total government expenditures). (Federal level allocations for health have doubled since 2004, and are probably adequate to cover the costs of 'federal functions'; state and LGA allocations are inadequate to cover the costs of secondary health and PHC.)
	2. The proportion of recurrent health expenditures allocated to non-salary overhead/ operating costs
8	1. Total health expenditures
	2. Proportion of each funding source
	3. Expenditure on health compared to health outcomes
	4. Comparison between health expenditure and policy goals
9	1. Total health funds available from different sources
	2. Per capita health expenditure
	3. Total expenditure on preventive health as a percentage of total health expenditure
	4. Government-funded health expenditure as percentage of total health expenditure
	5. Total Health Expenditure as percentage of GDP
10	1. Total health expenditures
	2. Health expenditures by major programs or disease interventions
	3. Health expenditures by subnational units/geographic areas
11	1. Public Health expenditure as a percentage of total health spending
	2. House hold expenditure as a percentage of total spending
	3. Donor expenditure as a percent of total health spending

	4. Proportion of total health expenditure on curative, prevention and promotive care
	5. Health expenditure on malaria, HIV/AIDS as a percentage of total Health expenditure
12	1. Government health spending (% of Total Govt spending)
	2. Govt contribution to total health spending
	3. Allocation of health spending to two specific programmes, HIV/AIDS and malaria
	4. Beneficiaries on programme allocations
	5. The patterns effectiveness of intra-programme allocations in HIV/AIDS and malaria (is this skewed towards drugs, HR, etc?)
13	1. THE as % of total govt budget
	2. % contribution by source
	3. Expenditure by levels e.g. curative Vs preventive
	4. Proportion spent by items/commodities e.g. pharmaceuticals
	5. Inter-country comparisons
15	1. Health expenditure per capita
	2. Proportion of government expenditure in the total of health expenditure
	3. Government expenditure on health as % of total government expenditure
	4. Health expenditure on each of three activities (Malaria, HIV/AIDS, Reproductive Health) as % of total health expenditure
	5. Out of Pocket as % of total health expenditure
16	1. Total health expenditures for households
	2. %of total government expenditure on preventive and promotive
	3. Health expenditures on malaria or HIV/AIDS
	4. Total expenditure of health administration
	5. Government expenditure for poverties areas
17	NHA just done
18	1. Total health expenditures
	2. Public health expenditures
	3. Health expenditures for following sub-sectors: malaria , tuberculoses, HIV/AIDS
	4. Household health expenditures
	5. Public expenditures to hospital
20	1. Government expenditures as % of total government expenditures
	2. Households expenditures as % of total health expenditures
	3. % of total health expenditures at the basic level health centers
	4. Execution rate of health expenditures in health facilities
	5. Per capita annual health expenditures
21	1. Out of pocket expenditure as % of THE
	2. Household expenditure as % of THE
	3. Public Sector expenditure as % of THE
	4. Private Sector expenditure as % of THE
	5. Contribution of Donors as % of THE
22	1. Total expenditure on health
	2. Government Health Expenditure as proportion of Total Government Expenditure
	3. Government Expenditure as proportion of Total Health Expenditure
	4. Total expenditure on preventive care as proportion of total health expenditure
	5. Total expenditure on capital as percentage of total health expenditure
24	1. Government expenditure on health as % of TGE
	2. Proportion of total exp on curative, preventive and promotive care
	3. Households' out-of-pocket spending as % of TE on health
	4. Health expenditures on diabetes as % of total health expenditure
	5. Health expenditure on HIV/AIDS as % of total health expenditure
25	1. Total Health expenditures % GDP
	2. Government expenditures on health % government expenditures
	3. Proportion of hospital expenditures % THE
	4. Proportion of the poorest quintile expenditures on health
	5. Proportion of THE on curative, preventive and promotive care

Appendix C.

Answers from question 10

Please list 5 reasons/incentives/motivational factors for using health expenditure data in your organisation

1	1. For resource allocation
	2. For planning
	3. For comparison with other countries
	4. For assessing health expenditure and better health outcomes
2	1. Justify budgetary allocation to the health sector
	2. Demonstrate that budgetary allocation has direct effects to health sector performance
	3. Support equitable distribution of resources
	4. Identify the cost effective interventions
	5. Assist allocating resources to different levels of health care
3	1. To inform the Development of Health Care Financing Strategy
	2. Social health insurance
	3. Monitoring &Evaluation of programs and policies
	4. Government Vision 2030 (Social Pillar)
4	1. To know the expenditures of the health and then write policies of health
5	1. Support policy formulation in the health sector
	2. Advocacy tool for negotiation/discussion with the Ministry of Planning and Development on the health sector resource envelope
	3. Monitoring and evaluation of the expenditure pattern in the sector
	4. Asses in what extent OOPs can limit most vulnerable groups to access to health care services.
	5. A way to assess if Governments are meeting their international/regional commitments on ensuring certain levels of funding for the Health Sector.
6	1. To know the total health expenditures
	2. Resource utilisation
	3. Distribution of resources
	4. System performance
	5. Plaidoyer
7	1. To see if and how donors technical assistance is influencing the government spending pattern at different levels over time
	2. To evidence our advocacy efforts for increased allocation towards the health sector
	3. To understand better where donors' contribution is most needed
8	1. To make evidence based decisions
	2. To keep track of the financial flow in the sector
9	1. Being a teaching and research organization; NHA is one of our major outputs
	2. We are the leading organization in the estimation of NHA in Nigeria
	3. The University as a centre of learning encourages our programme to blaze the trail in several areas of research in health economics including NHA

10	1. To capture trends across the years
	2. To compare performance across countries
	3. To compare performance relative to health service coverage or outcomes or other measure of performance
11	1. Donors, on their funding allocation decisions
	2. Researchers, to further field of international development
	3. Programme Managers to see how important their programme is in relation to total health expenditure
	4. For purposes of planning for the future by various institutions
	5. Wanting to know whether money is going to right priorities
12	1. NHA data complements many research efforts of the Department
	2. NHA provides opportunities to compare other datasets and help to improve research outputs
	3. Allows for greater robustness in terms of information/outputs with which to engage policy makers
13	1. To project on future spending by looking at historical data trends
	2. To determine/predict levels of outputs/outcomes
	3. Set target indicators
	4. Determine transparency and efficient use of resources
	5. Establish equity in terms of resource allocation and distribution
14	1. It gives the health financing picture
	2. It helps in building the case in resource mobilisation
	3. It helps in equitable allocation of resources
	4. It is the only objective way of analysing key stake holders in health financing
	5. The current management are interested with the facts/ data than mere stories
15	1. To know the global amount that government and all partners put in the health sector
	2. To allow to assess the efficiency of resources used in the health sector
	3. To have an idea on the allocation of resources in different health programs
	4. To allow the comparison with other countries with similar economic situations
	5. To help Government decide how to reallocate resources in health sector
16	1. My organisation is a head team for planning and management in the health system
	2. It is responsible for survey and data collection for the health department
	3. It make tools for pladoyer for health
	4. It define policies and priorities for health department
	5. It is responsible for evaluating and looking for health programmes and projects
17	1. Compare de costing of health with standards and other countries
	2. More for helping the MoH and allow our organization to advise as good as could be expected for taking the best decisions than for the organization self
18	1. For elaborating health economic documents
	2. For making budgets for health programmes
	3. For tracking health expenditures
19	1. Making decision
	2. Providing information for the global MTEF
	3. Providing information for the evaluation of MDG
20	1. Planning, allocation of resources
	2. Cost-effectiveness
	3. Health Mutual care (Mutuelles de santé)
	4. Governance in health sector
	5. Household “burden” as on health expenditures
21	1. To trek pattern of expenditure on health services
	2. Can help influence policy and strategic plans
	3. Can help in decision making and prioritisation
	4. Can help support health system governance
	5. Financial Planning, monitoring and evaluation

22	1. To lobby for more resources from both government and donors
	2. To influence equitable and efficient resource allocation
	3. A source for further studies e.g. hospital efficiency studies, Public Expenditure Reviews
	4. A means for improving management of resources at unit level e.g. reduction in travel costs
23	1. Planning
	2. Resource allocation
	3. Policy formulation
	4. Monitoring
	5. Performance
24	1. To provide evidence-based information to policy makers
	2. To improve equity and access to free health services
	3. To negotiate with donors
	4. To assist government in promoting private stakeholders to invest more in health
	5. To negotiate with Ministry of Finance
25	1. To increase resources allocation for the hospitals
	2. Optimal allowances of resources per level of the system of health
	3. To evaluate the proportion of the poorest expenditures of health
	4. Evaluation of the proportion of the donors on the THE
	5. To increase the proportion of the government expenditures on health
26	1. Assess which are sources of health care financing the health sector
	2. Demonstrate who benefits from public health funding
	3. Illustrate the difficulties in sustainability
	4. Aiming in triggering strategic thinking of new options to address healy donor reliance
	5. Assess total magnitude of funding to the health sector

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

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