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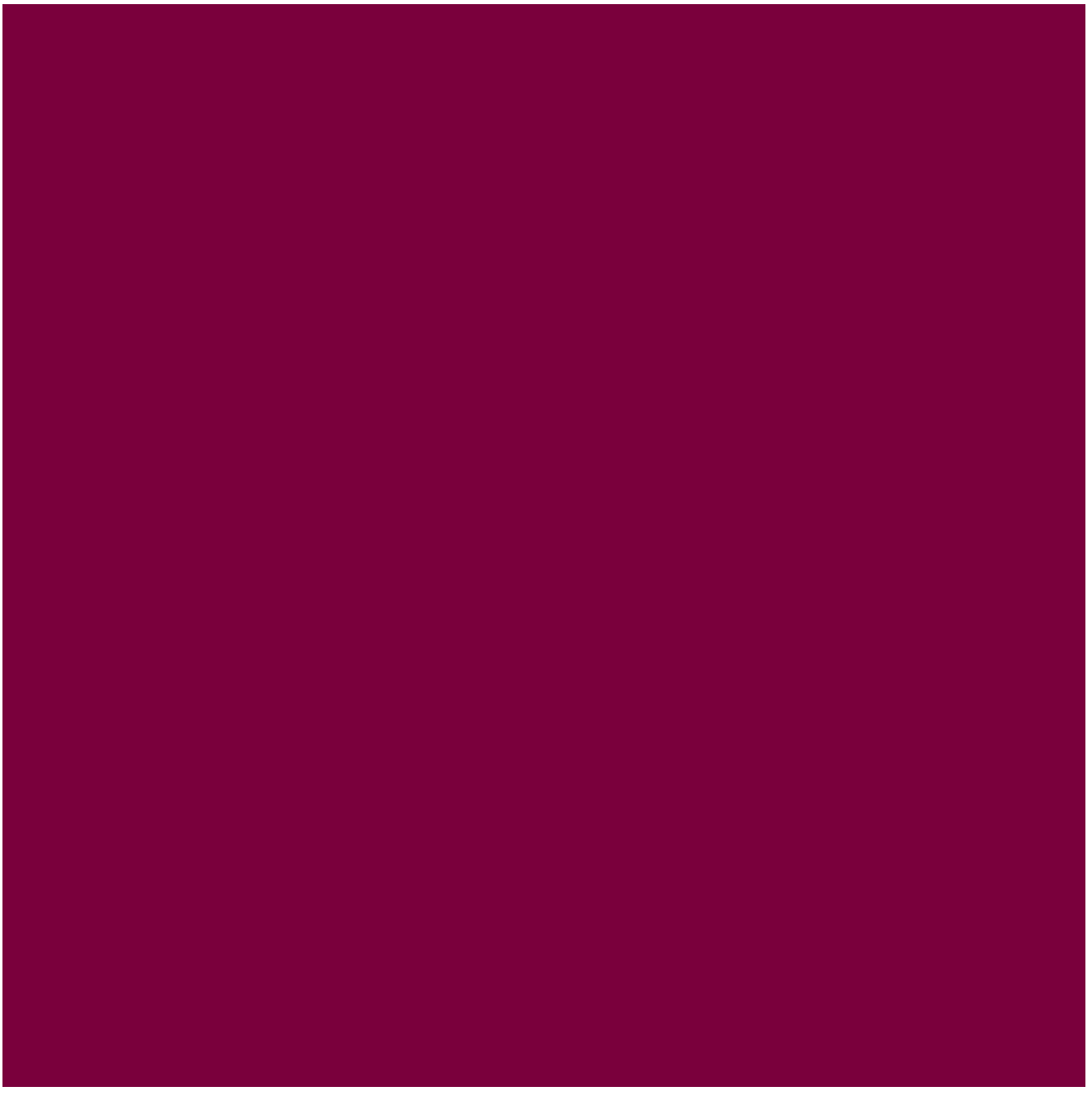
Are health accounts and disease specific information useful for global health initiatives/programmes?



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Abbreviations

AIMS	Assessment Instrument for Mental Health Systems
DAC	Development Assistance Committee
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIS	Health Information Systems
HMN	Health Metrics Network
mhGAP	mental health Global Action Programme
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
M&E	Monitoring and Evaluation
NAA	National AIDS Accounts
NASA	National AIDS Spending Assessments
NHA	National Health Accounts
NIDI	Netherlands Interdisciplinary Demographic Institute
OOP	Out-of-pocket
RBM	Roll Back Malaria
RH	Reproductive Health
ROW	Rest of the World
SHA	System of Health Accounts
Sida	Swedish International Development and Cooperation Agency
SWAp	Sector Wide Approach
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WB	World Bank
WHO	World Health Organization

1. Background

The Swedish International Development and Cooperation Agency (Sida) works with countries to enable their health systems to ensure universal access to essential health services. Sida's work on Health System Development focuses on issues that relates to the functioning of the overall health system. It is concerned with issues such as health sector reform, health policy formulation, the organisation of the health sector and the financing of its activities. Sida recognises that the way health systems are designed, financed and managed affects people's lives and livelihoods. The reformation of health systems can improve health outcome as well as financial protection, service and efficient use of resources. Funding of health sectors in developing countries is an important part of development support. Naturally, the flow of money is the subject of intense debates within the donor community. Accurate information about spending on health services and public health programmes is needed for e.g. policymaking, priority setting, monitoring and evaluation (M&E) of the use of funds. For donors it is also important to accurately determine how any additionally provided funds are used so that these do not replace nor reduce other sources of funding.

NHA (National Health Accounts) is a useful instrument when international donors require a country to have systems for programme implementation, financial reporting, and programme M&E. Since the early 1990s the interest regarding health accounts and the production of health accounts has grown. Its usefulness in health sector reform work has also become evident, which has encouraged large international organisations, such as the World Health Organization (WHO), World Bank (WB) and several donor agencies, to become more involved in the area of health accounting and health expenditure tracking. Collecting data on national health expenditures is useful for several purposes, e.g. those countries that have received increased levels and diversity of health funding to combat a disease are required by donors and governments to show accountability for those funds. Health accounts can provide that information. They reveal trends in health expenditure over time and are a valuable element in health system M&E.

The Center for Global Development has formed an international Resource Tracking group to identify specific ways to enhance the accuracy, timeliness, comprehensiveness and accessibility of information on public and private financial flows for health in developing countries. The working group conducted a series of background analyses and generated

specific recommendations targeted specifically at the international community. The recommendations were submitted to the High Level Forum on the Health Millennium Development Goals[1] in November 2005. The outcome of the working group's efforts is four basic recommendations;

- donors and international agencies should support improvements in the ability of developing country governments to develop sound budgets and report on their execution;
- donors and international agencies should support the integration and institutionalization of NHA into policymaking in developing countries;
- efforts should be made to improve data on private spending;
- donors should work collectively to support and refine global level information systems (Global Health Resource Tracking Working Group 2005).

The Millennium Development Goals (MDGs) sets different targets on a number of global priorities, of which combating HIV and malaria are two diseases mentioned. This has highlighted the need for more disaggregated health expenditure data and work has been initiated to develop sub-accounts for specific health priorities, e.g. HIV and malaria (De, Dmytraczenko et al. 2004). Sub-accounts use the NHA framework to track expenditures on health for specific diseases, interventions, age groups, or specific geopolitical regions. With only a minor expansion of the data collection it is possible to produce additional results for the mentioned categories linking information in a matrix format between different Financing sources, Financing agents, Providers or Functions. The interest for disease specific information was so high at UNAIDS that the organisation decided to develop its own methodology for tracking health expenditures on HIV/AIDS.

Since the work of implementing health accounts in developing countries started in the 1990s, an increasing number of countries have realised its potentials. Donors and multilaterals promoting health account's implementation often bring up its usefulness in e.g. health sector reform.[2] However, when it comes to global health initiatives (which donors and multilaterals actually are funders of) the usefulness of health accounts has not been fully recognised.

In light of this, it is relevant to investigate what needs global initiatives have for M&E their activities[3]. M&E of the use of funds in global health initiatives need not to be seen as isolated exercises. On the contrary, they could be undertaken with the aim of reaching several benefits. Tracking the progress and effectiveness of international programmes and efforts to fight major health problems such as HIV/AIDS does not necessarily only provide an overview of how the money have been spent, it can also provide an evaluation of what is working and what is not. This helps in planning better programmes and how to more efficiently use resources in the future.

NHA tracks finances from sources to users in the health system as a whole as well as within disease- or intervention-specific sectors (i.e., HIV/AIDS, reproductive health), and it produces data to compute key finan-

[1] The goals were agreed to by 189 countries in the UN assembly in the year 2000.

[2] It has been brought up, as a critique, that the actual users of health accounts many times are multilateral organisations and donors.

[3] See Appendix III for more information about M&E in global health initiatives.

cial indicators. There are great possibilities for using NHA as an instrument for increasing transparency of the use of funds for special initiatives. Rwanda is one such example where HIV/AIDS health accounts were used to show that health sector spending on HIV/AIDS to more than 90 percent went to treatment and care rather than prevention. The accounts also revealed that 93 percent of the spending was financed by households (Barnett, Bhawalkar et al. 2001).

1.1 Purpose

The overall objective of this report is to present information on the actual, and the potential, use of health accounts by specific health programmes at global initiatives level. More specifically, three questions are addressed:

- What health expenditure data is important?
- What is the purpose of using national health accounts as well as sub-accounts among global health initiatives/programmes?
- What is needed and what should be done to increase the awareness and use of health accounts at a global level?

1.2 Method

This study is based on questionnaires, literature reviews and interviews.

Two questionnaires were sent to persons working in key functions at global health initiatives/programmes and organisations working/collaborating with global health initiatives/programmes (See appendix I and II for the questionnaires). The objective of the first questionnaire was to find out how health expenditure data in general, and NHA in particular, is being used, and if not used - why not, and how it can be used by multilateral organisations and donors in global health initiatives. It was sent out by e-mail to 50 potential respondents and in addition two reminders were sent. The objective of the second questionnaire was to focus the usefulness of NHA and what kind of health expenditure data and information is important for global health initiatives. Therefore, it was sent to the respondents who, in the first questionnaire, considered that the use of NHA has potential advantages for their activities. The second questionnaire was sent by e-mail to 30 respondents and further two reminders were sent. IHE developed the questionnaires with valuable assistance from WHO.

The purpose of the literature search was primarily to find information about the global health initiatives (presented in chapter 2). Interviews were held with persons working in key functions at global health initiatives in order to complement the background information obtained from the literature search and the questionnaires.

2. Global health initiatives/ programmes

Global health initiatives and programmes are in this study limited to common, global efforts to support specific areas of health or diseases that affect a large part of the world population. According to this, we have identified eight initiatives, which are briefly presented below.

2.1 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund was created in 2002 to increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. The Global Fund is a partnership between governments, civil society, the private sector and affected communities. In awarding grants, the Global Fund gives priority to countries and regions with the greatest need, based on the highest burden of disease and the fewest financial resources available to fight these epidemics.

The aim is to establish a simplified, rapid and innovative grant-making process and operate transparently, with accountability. While the concept of performance-based grant-making is not new, the Global Fund is pioneering practical systems to implement this approach that balance the need for accountability and efficiency. This includes working with recipient countries to identify a small number of key indicators to be used to measure progress, and ensuring that, where possible, Global Fund reporting requirements rely on existing processes. The use of Local Fund Agents is another accountability mechanism designed to provide appropriate oversight while respecting local implementation.

The Global Fund's commitment to transparency is illustrated by the broad range of information available on its website. All approved proposals and signed grant agreements are available for review in unedited form, as are documents discussed at Board meetings.

The Global Fund's M&E strategy builds, as far as possible, on existing country level and global systems for monitoring and evaluation to provide reliable, quality information to satisfy the strategic needs of the Fund and its stakeholders. The Fund recognizes the challenges to effective monitoring and evaluation from inadequate data quality assurance systems and weak M&E capacity in many grant-receiving countries. Fund grants may be used to strengthen national M&E capacities and the Fund encourages joint partner efforts to this effect.

2.2 Roll Back Malaria (RBM)

The RBM Partnership was launched in 1998 by WHO, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP) and the WB. The programme was created to provide a coordinated global approach to fighting malaria and the goal is to halve the burden of malaria by 2010.

The RBM Partnership has grown since 1998 and is now made up of a wide range of partners. These include malaria-endemic countries, their bilateral and multilateral development partners, the private sector, nongovernmental and community-based organisations, foundations, and research and academic institutions. Partners are working together to scale up malaria-control efforts at country level, coordinating their activities to avoid duplication and fragmentation and to ensure optimal use of resources.

The RBM partnership has formed a special group to deal with M&E activities called "The Monitoring & Evaluation Reference Group (MERG)" which meet on a regular basis. The purpose of the group is to act as an advisory body for the RBM Secretariat on all matters pertaining to monitoring and evaluation on the international, regional, and national levels and to provide technical advice on state-of-the-art approaches to M&E of malaria programmes. The technical focus is on the global indicators to assure consistency and accuracy in national and regional reporting. The functions of the group are to develop and provide technical guidance on appropriate data collection methods, analytic strategies, and dissemination of recommendations. The group also identifies critical technical questions arising from M&E activities and organises smaller working groups to address the questions and provide technical feedback. Their role is also to develop and maintain consensus around M&E strategies across partners and institutions, as well as to identify and recommend strategies for addressing the needs for capacity building at all levels.

A draft version of guidelines to estimate malaria expenditure on health has been prepared by WHO and PHRplus. The methodology for malaria specific health accounts has been developed and so far used in two countries (Rwanda and the Philippines). It is the first time the financial flows in the field of malaria have been investigated following the structures of the NHA tables. In the 2003 version of Rwanda National Health Accounts a malaria sub-analysis was included. This work informed the drafting process concerning the international guidelines on conducting malaria sub-analyses. There is a clear recognised need for disease specific accounts by the malaria programme, and the RBM programme is interested in implementing the accounts in Mozambique during 2007. Other potential countries to follow are Benin and Ethiopia.

2.3 Global Alliance for Vaccines and Immunization (GAVI)

The GAVI was formed to tie together the force and experience of the partners in the work of immunization. GAVI was launched by a public and private partnership in year 2000 to improve access to vaccines in the poorest countries of the world. To finance the mission the alliance created the Vaccine Fund. The alliance brings together governments in developing and industrialized countries, vaccine industry in developing countries, vaccine industry in industrialized countries represented by IFPMA (the International Federation of Pharmaceutical Manufacturer's Associations), nongovernmental organizations (NGOs), research and

public health institutes, WHO, UNICEF, the Bill & Melinda Gates Foundation and the WB.

GAVI gives three types of support, 1) vaccine, 2) safe injection supplies, and 3) financial support. For the two first kinds of support no cash flows into the country, only goods. The financial support is based on country targets for how many children will be immunized and 20 USD per child is received. The funding system of GAVI is performance-based which creates financial incentives for countries to improve the immunization coverage. Countries are awarded three years of investment payments based on their goals for the number of additional children to be immunized. After three years the countries are evaluated and private consultants are sent into the field to visit health clinics to get immunization information and see how many children have been immunized (Data Quality Audits). If the target is reached the country will get 20 USD for each child immunized in next phase, otherwise less. Some countries have created specific GAVI accounts to make sure that the money is not absorbed in the Ministry of Finance (MoF) or the Ministry of Health (MoH) budget. After five years of support the countries need to replace the Fund's support with other sources of funding, as e.g. the government's own budget or development loans. GAVI provides the countries with planning tools and guidelines for this phase, e.g. workshops on how to develop a Financial Sustainability Plan.

2.4 Stop TB Partnership

The Stop TB Partnership was established in 2000 with the aim to eliminate tuberculosis (TB) as a public health problem through increasing access to diagnosis and treatment, by supporting research and through creating and coordinating strategies in countries with high burden of TB. It is a network of international organisations, countries, donors from the public and private sectors, governmental and non-governmental organisations and individuals. In 2004 Stop TB had more than 300 partners (NGOs, governmental organisations, academic institutions, businesses, individuals and others). WHO is a leading agency in the Stop TB partnership and provides guidance on global policy and WHO Geneva houses the Stop TB Partnership Secretariat. The secretariat follows the rules and regulations of WHO for its administrative, financial and human resources management. The Stop TB Partnership includes The Global Drug Facility (GDF) which is a mechanism to expand access to and availability of TB-drugs. It has four core financial donors, i.e. the Canadian International Development Agency (CIDA), the Netherlands, the WB and the U.S. Agency for International Development (USAID).

2.5 Mental health Global Action Programme (mhGAP)

Mental health has during the latest years become a major international public health concern and WHO has brought up the importance of mental health. The World Health Day in 2001 was devoted to mental health and the topic of the World Health Report 2001 was mental health. The report provides a review of what is known about the burden of mental disorders, its major causes and it also examines prevention issues and the availability of treatment.

The mental health Global Action Programme (mhGAP) was developed as a follow-up to the 2001 World Health Report and has a strategy aiming at closing the gap between what is urgently needed and what is currently available to help individuals and families affected by mental

illnesses. The programme aims to increase the responsiveness of governments to mental health concerns, to improve services, to reduce the burden of mental disorders, and to reduce the devastating impact of stigma and discrimination. It is a five-year programme that focus services for the most vulnerable population groups and prevention, treatment and rehabilitation for people with e.g. depression, schizophrenia, alcohol and drug dependence, dementia and epilepsy. As the programme on Mental Health realised the importance of accurate data, a new project started called WHO AIMS (Assessment Instrument for Mental Health Systems). This project focused three pieces of data on financing of mental health services; 1) Mental health expenditures by the government health department 2) Expenditures on mental hospitals, and 3) Mental disorders in social insurance schemes.

2.6 Child and reproductive health

Two of the targets included in the MDGs are reductions in maternal and child mortality. These targets have resulted in that many developing countries have set an agenda as to improve reproductive health (RH) and child health services, which of course requires additional resources or reallocation of existing funds.

Unlike the other initiatives presented in this chapter there is not a single structure for child and reproductive health so we have chosen to present two separate programmes as follows.

The Strategic Partnership Programme (SPP) between the WHO and the United Nations Population Fund (UNFPA) aims at promoting sexual and reproductive health at both national and sub national levels. Countries are supported through systematic dissemination and local adaptation of guidelines in family planning, prevention and control of sexually transmitted and reproductive tract infections, and maternal and newborn health.

The Partnership for Maternal, Newborn and Child Health is a global health partnership launched in September 2005 aiming at achieving MDGs 4 and 5. This partnership is a joint effort of three existing partnerships: the Partnership for Safe Motherhood and Newborn Health, the Child Survival Partnership and the Healthy Newborn Partnership. The Partnership has the goal to intensify and harmonize national, regional and global action to improve maternal, newborn and child health. The Partnership is constituted of around 80 members representing partner countries, UN and multilateral organisations, nongovernmental organisations, health professional associations, bilateral organisations and foundations, and research institutions.

PHRplus has produced a concept paper on how NHA can be adaptable to fit the RH context (PHRplus 2005). As for general NHA the subanalysis for RH organises the health expenditure data in the standard table format with financing sources, financing agents, providers and functions. The NHA sub-analysis can answer the following questions: how much is spent on RH, what is the reliance on donors for RH services, what is the proportion of RH financing coming from private sources, e.g. households, what is the relationship between expenditure and outcomes and what types of services are financed by RH funds. As of June 2005, NHA subanalyses for RH had been conducted in Egypt, Jordan and Rwanda. At the same time efforts were underway in India and Mexico. The Institute of Policy Studies prepared a review of costing and financing of RH services for Bangladesh, Rajastan (India) and Sri Lanka. This review used the national accounting framework.

2.7 UNAIDS (Joint United Nations Programme on HIV/AIDS)

UNAIDS gathers the efforts and resources of ten UN organisations for fighting HIV/AIDS. Collaborating partners include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the WB. UNAIDS harmonizes monitoring and evaluation efforts at global, regional and country levels to provide accurate and timely information on the disease. The Country Response Information System (CRIS) is an information system for monitoring and evaluating national efforts to fight HIV/AIDS.

In 1995, the Regional HIV/AIDS Initiative for Latin America and the Caribbean (SIDALAC) started to adapt the framework of NHA to the estimations of flows of funds and expenditures on HIV/AIDS, i.e. the National AIDS Accounts (NAA).

NASA (National AIDS Spending Assessment) is a system of resource tracking developed by UNAIDS. There is an ongoing work of producing a notebook on methods, definitions and procedures for the measurement of HIV and AIDS financing flows and expenditures at country level by UNAIDS. According to the draft version of the NASA notebook, NASA is consistent with standardised methods, definitions and accounting rules of the System for Health Accounts (SHA). However, there are components not available in SHA that are needed if to take into account all HIV/AIDS actions. The International Classification of Health Accounts (ICHA) is very limited for answering questions when making policies and resource allocation decisions within the area of HIV/AIDS. Many NASA categories cannot be linked to existing NHA categories.

Workshops for NASA training are organised and there is also a software available to facilitate NASA training, data entry, analysis and reporting of international, public and private spending.

The NASA classifications are harmonised with the UNAIDS initiative on resource needs estimates that is outlined in the document "Resource Needs for an Expanded Response to AIDS in Low- and Middle-Income Countries" (UNAIDS 2005). Therefore, NASA is not limited to health expenditures but also includes the tracking of social mitigation, education, labour, justice and other sectors' expenditures. Following six vectors for each transaction have been developed: Financing sources, Financing agents, Functions (HIV/AIDS-related interventions and activities), Providers of services, Components or factors of the production function and Beneficiaries.

2.8 Health Metrics Network (HMN)

The Health Metrics Network (HMN) is a global partnership aiming at facilitating better health information at country, regional, and global levels. HMN is trying to bring together health and statistical entities in order to increase the availability, quality and use of data for decision-making in the health sector. It is founded on the premise that better health information leads to better public health decision-making that will improve health for millions worldwide. Partners include developing countries, multilateral and bilateral organisations, foundations, other global health partnerships, and technical experts. The co-sponsors of the HMN are, among others, the Bill and Melinda Gates Foundation, the Department for International Development (DFID), USAID, and the Danish International Development Agency (DANIDA).

HMN views resource tracking as a key data source, and by combining data-sources the programme is trying to strengthen ways of tracking resources. In this work collaboration with national statistical offices is an

important ingredient. HMN will pursue three interrelated objectives:

- Create a harmonized framework for country health information system development (the HMN framework) which describes standards for health information systems;
- Strengthen country health information systems by providing technical and catalytic financial support to the application of the HMN framework; and
- Ensure access to and use of information by local, regional, and global constituencies.

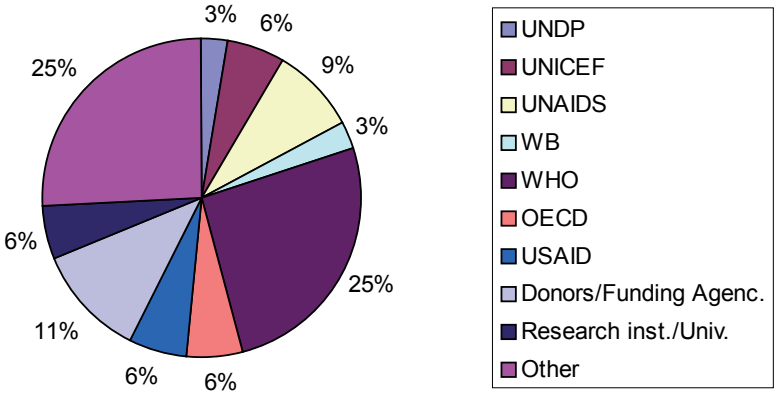
3. Potential use of health accounts by Global Initiatives

This chapter includes first a section describing the responses and respondents of the two questionnaires. The subsequent sections present results from the two questionnaires and are structured as to answer the specific questions addressed in the purpose of the report, i.e. what health expenditure data is important, what is the purpose of using national health accounts as well as sub-accounts, what is needed and what should be done to increase the awareness and use of health accounts at a global level.

3.1 Responses and respondents

After two reminders we received 35 responses out of 50 persons that were identified as respondents for the first questionnaire. The respondents worked for the organisations and institutions as presented in figure 1. The reason behind the high representation by WHO is that many global health initiatives are found within the WHO organisation. The respondents worked for one or several of the following health initiatives: GFATM, HIV/AIDS resource tracking, RBM, Stop TB, GAVI, international health resource tracking, child survival partnerships, mental health, resource tracking for the elderly or resource tracking for research initiatives in health.

Figure 1. Respondents by organisation[4]



[4] The category Other included e.g. Kaiser Family Foundation, UNFPA, UEMOA, NGO, IDB, ADB

After two reminders to the 30 potential respondents for the second questionnaire the final number of respondents was 21. More than 50 percent of the respondents answered that their organisation/programme currently have an internationally comparable database on expenditures that is publicly available. Half of the respondents have standard guidelines to compile an internationally comparable database and most of them claimed that these are compatible with NHA. Out of those not having guidelines almost all claimed their programme would be interested in having such guidelines.

3.2 Which health expenditure data is important?

The first questionnaire covered questions related to the use of health expenditure data in general. Almost all respondents, 90 percent, rated the *relevance* of using health expenditure data in their respective organisation as 'high' or 'very high'. Apart from health accounts, the sources of data used by the programmes are multiple; MoH and MoF, Demographic and Health Survey (DHS), UNSTATS, Netherlands Interdisciplinary Demographic Institute (NIDI), WHO, ATLAS, WB, IMF, DAC etc.

The last part of the first questionnaire asked questions about NHA in particular. The majority of the respondents were familiar with the concept of NHA and almost 8 out of 10 answered that they use NHA in their respective organisation.

Almost all the organisations/programmes thought that it is 'important' or 'very important' to know the sources of funding (i.e. general government, social security expenditures, private health insurance, NGOs, out-of-pocket and external resources) for their respective programme in any given country. One question revealed that most organisations/programmes track expenditures originating from the government. Around 50 percent of the respondents track social security expenditures, expenditures from NGOs and out of pocket expenditures. More than 50 percent of the respondents track external resources while only a part tracks private health insurance expenditures.

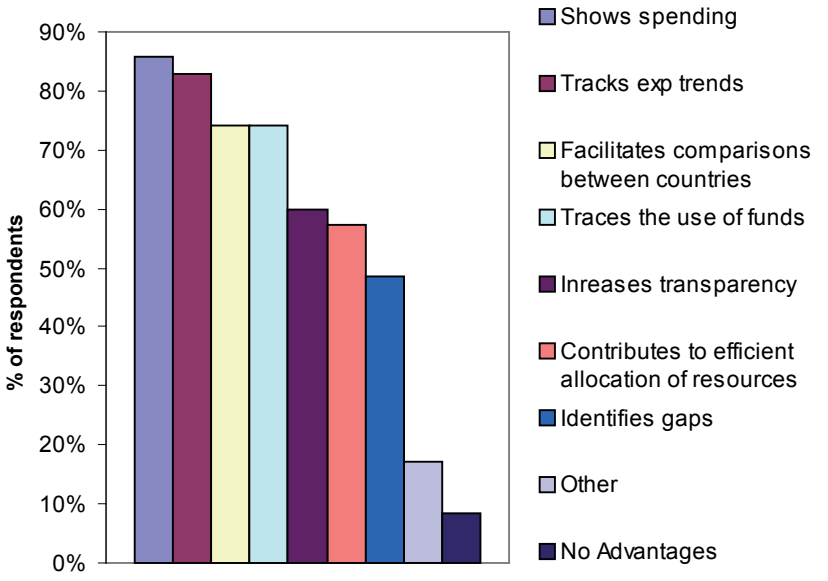
3.3 What is the purpose of using National Health Accounts?

In order to map the purposes of using NHA one section of the questionnaire focused on that. Three thirds of the respondents answered that they *use* health expenditure data for M&E purposes in their respective organisation 'sometimes', 'usually' or 'always'.

In an open-ended question the respondents were asked in what way they used the information provided in NHA. Three main areas of use were identified: for health system performance; for sub-analysis; and for monitoring of projects.

As demonstrated in figure 2 most respondents thought that the use of NHA had potential advantages in that it showed spending on different health activities and tracked health expenditure trends. The majority of the respondents also viewed comparisons between countries and the tracking of funds as potential advantages when using NHA. Around two thirds of the respondents thought that the use of NHA increased the transparency. Sixty percent of the respondents thought that the use of NHA contributed to efficient allocation of resources and a bit less than 50 percent thought that it identified gaps for resource needs. Only seven percent (3 respondents) claimed that NHA had no potential advantage for their activities.

Figure 2. Which are/would be the potential advantages of using NHA in Your activities?



The majority of the respondents thought that it is 'important' or 'very important' to know how much of total health expenditures is spent on other programmes in the country's health sector. Only a few thought that it is 'less' or 'not important' to know how much is spent on other programmes.

Some respondents also commented on how health accounts are useful for them in their activities;

"NHA does play an important role and the data could be used more frequently than they are. To a certain extent it is an issue of the Government not using it as they should in policy making."

"The crucial role NHA can play in global disease specific programs is to map and show how much resources is spent on specific diseases, but [also, and] more importantly how these resources flow through the health system. NHA could work better to reveal how initiatives often fund health in parallel making delivery of both public health and health care services less efficient.

"NHA data is extremely useful in the design of health financing mechanisms"

3.3.1 Why are disease specific accounts useful?

To date very few countries have developed or published sub-accounts. During the interviews, it became clear that if disease specific health accounts were to be implemented in more countries, the great majority of the global health initiatives/programmes would be very interested in using the information provided by these.

The AIDS specific accounts contain valuable and useful information for e.g. GFATM that could be used both for evaluation purposes and for planning purposes. In fact, the organisation finds health accounts most useful for the proposal processes and for target settings as well as for transparency issues. According to GFATM, the current difficulties with using health accounts, for their purposes, is that there are not enough disease specific components available. GFATM needs disease specific data and trend data on how additionality works in the countries. It is important to find out if donors actually add funds to a specific area or if the funds only are substituting other sources of funds.

Currently, data collection of health expenditures on malaria is almost non-existing at country level. Making this kind of information available would facilitate for better target in-country support and improve coordination attempts. The RBM programme is very interested in being able to link inputs to actual outputs. This would assist an efficient resource allocation of malaria specific funding within the health sector, as well as for evaluation of current funding.

As of today NHA is not used as an instrument for monitoring the use of funds provided by GAVI to developing countries for immunization. GAVI recognises that in the future the data requirements for their activities are likely to change and that NHA would fulfil some of their needs in terms of expenditure tracking. Another possibility in the future is that expenditure tracking and the use of NHA actually will be required by e.g. WHO.

The programme on Mental Health is interested in using NHA subaccounts. However, currently no guidelines have been developed for accounts on mental health and the programme is looking for funding to put these together. Two clear benefits of such accounts are identified. Firstly, the methodology for such accounts would help countries put together disaggregated data in systematic way. Secondly, the now suspected inefficiencies in health systems regarding the use of resources for mental health can become visible. This will help in guiding countries towards a more efficient usage of available resources.

The Health Metrics Network (HMN) aims at providing better information from developing countries through coordination of different sources of data. Since health accounts is one such source of information, sub-accounts for different health problems is viewed as important. The sub-accounts developed need to be linked to existing data sources and systems. Decision makers must be able to ask specific questions on the use of resources and the answers should be provided by the health accounts. The HMN recognises that in countries where more than one health account report have been developed substantial benefits of these accounts can be found.

In sum, the interest and use of sub-accounts seem to be dependent on the availability of sub-accounts and corresponding guidelines and on internal needs as e.g. when creating proposals, in planning activities and for efficiency issues.

3.4 What is needed and what should be done to increase the awareness and use of health accounts at a global level?

In the first questionnaire the respondents were asked to rate whether different aspects of health expenditure data constituted a problem/limitation when using the data. The aspects asked about were; the *availability of data*, the *coverage/breakdown*, the *regularity*, the *relevance*, the *quality*, the *timeliness* and the *comparability across countries*. Almost all aspects were seen as a 'problem', a 'big problem' or a 'major problem'. The only aspect that differed noticeably from the others was the aspect of relevance. For this aspect almost as many rated it a 'none or minor problem' as who rated it a 'big or very big problem'.

At the end of the first questionnaire the respondents were allowed to comment on their demand for more specific data. Some comments indicate the actual need for disease specific sub-accounts:

"Traditional NHAs can only provide selected data. They do not provide recent funding data, private OOP funding and non health funding for AIDS so they must be supplemented with other data collection activities."

Several respondents commented on the importance of knowing more about policy use:

"Contribution of NHA to policy formulation is underdeveloped. Knowing how much you spend, by itself, is useless. Countries have recognized the problem and are using interest in NHA".

"A systematic study of policy uses is required: in the past and the expected uses".

" It will be important to show how such data can be used in the policy process, capacity building in the ministries. Furthermore, it is of course sometimes sensitive politically; this is something that the partners locally will have to deal with on a case by case basis. It is very important that NHA publications are widely disseminated and that they are easy to read!"

"A major data gap is the lack of regular collection and reporting on national statistics on population by sex, (the denominator for any health-related rates etc.), and national statistics on health status, disability status etc. The gap stems in large part from lack of capacity of national statistical offices. More effort needs to be put into building this capacity so that countries can generate high quality, reliable and regular national statistics. This will not happen if NHA data collection activities remain separate from those of national statistical offices. Ministries of Health and Ministries of Statistics/National Statistical Offices (and WHO) need to work more closely together in this regard."

"We feel confident about the data reported within our systems while recognising that financial reporting is perhaps the weakest element of our data system. Hence, better understanding and use of NHA would potentially be of benefit. This would be especially useful in monitoring the additionality of resources and would also have potential benefit in achieving greater harmonisation, alignment and accountability."

"We also note some limitations with NHA, in particular, it should be possible to make the categories more "generic" and more policy relevant, as well as to eliminate some inconsistencies. To be more policy relevant, the NHA categories should map clearly into the health financing framework".

In the second questionnaire all respondents, except one, thought that it is important for their organisation/programme to track whether the health resources are efficiently allocated. The follow up question asked the respondents to rate the importance of tracking different kinds of allocations. The proposed allocations were: *allocations between resource costs*, by *provider categories* (hospitals vs primary care facilities), by *functions* (inpatient vs outpatient care), by *functions* (curative vs preventive care), by *population groups* (income categories, gender, age), and of *expenditures at district level* or other *geopolitical levels*. The majority of the respondents rated the importance of all the options as 'high' or 'very high'. Only a very few rated the importance as 'low' or 'very low'.

Nine of the 21 respondents stated that information on expenditures for inpatient vs outpatient care is important to their respective organisation/programme at the aggregated level only. Ten respondents answered that information on the level of inpatient or outpatient for specific diseases or subgroups is important where e.g. HIV/AIDS, malaria, TB, reproductive, maternal and child health, were mentioned as being of specific interest.

The respondents were asked to list five important indicators that they would like to track for health expenditures within their respective programme. All, except one, of the respondents presented a list of indicators. Indicators were listed within the areas of HIV/AIDS, malaria, TB, mental health, reproductive health as well as indicators for age groups, the geopolitical level and for specific interventions (e.g. child health). Common indicators listed as important were the share of disease specific

expenditure of total health expenditure, disease specific expenditures divided into prevention versus treatment and care, how much households spent on specific diseases and disease specific expenditures on inpatient versus outpatient care. The complete list of preferred indicators can be found in Appendix IV.

According to UNAIDS, health accounts are often not timely enough. In addition, policymakers working with HIV/AIDS need more detailed information than NHA can provide. The newly developed system for expenditure tracking by UNAIDS (NASA) is considered as a tool that will be useful for GFATM. As the organisation needs trend data on how additionality works in the countries. It is important to understand if the donors are adding funds and not only substituting funds already available. GFATM is also in need of disease specific data. The organisation is currently working with WHO on the issues of additionality and health accounts. Governments, bi- and multilateral organisations require that funds are correctly used for given purposes. When funds are made available it is often important to make sure that these funds are provided as an additional financial resource, not replacing or reducing other sources of funding. For example, the Global Fund "will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria" (The Global Fund to Fight AIDS Tuberculosis and Malaria).

Today, too many data collection methods exist and standardised methods are needed. If HIS can be better coordinated much would be gained. According to HMN, health accounts must be harmonized in terms of terminology and definitions used in resource tracking. Combining different data sources in countries is very much the key towards an improved HIS. This would facilitate the process of implementing and institutionalising health accounts, as well sub-accounts. However, it is important not to burden countries with demands of too detailed reporting of health problems – this should stem from countries' specific needs.

Additionality can be traced in NHA by measuring financial changes for a specific priority when new funds (Rest of the World, ROW) flow into a country (Garg 2005). It is possible to track the increased overall investment from ROW in the economy for a specific priority, increased domestic expenditures for that priority, and the reallocation of government resources that would otherwise have been allocated for that priority.

4. Conclusions

Based on this study we can conclude that the majority of the programmes and organisations working with global health initiatives find it highly relevant to use health expenditure data in their respective organisation and the majority often use health expenditure data for M&E purposes.

We find that most initiatives/programmes are familiar with the concept of NHA and many of them use health accounts in their respective organisation. Some of the programmes and organisations currently have an internationally comparable database on expenditures that is publicly available. Some programmes have developed standard guidelines to compile internationally comparable databases out of which several are claimed to be compatible with NHA. Among the initiatives/programmes who lack guidelines there is an interest in developing such. Almost all the organisations/programmes emphasize the importance of knowing whether there is an efficient allocation of health resources for their respective programme in any given country. They also accentuate the importance of knowing the sources of funding as for example general government, social security expenditures, private health insurance, NGOs, out-of-pocket and external resources. Moreover, there is also an interest in having such information for other programmes in the health sector.

As NHA is increasingly used worldwide, the demand for information about expenditures at sub-national levels and disaggregated information into disease, intervention and other detailed categories with more disease specific information is growing. Resources have been spent on developing guidelines of how to conduct sub-accounts for HIV/AIDS and malaria, however their implementation has been long-drawn-out and today very few countries have developed or published sub-accounts.

The results from this study indicate that the great majority of the global health initiatives/programmes are very interested in developing and using sub-accounts and the interest and use of sub-accounts seem to be dependent on the availability of sub-accounts and corresponding guidelines and on internal needs as e.g. when creating proposals, in planning activities and for efficiency issues. Thus, guidelines of how to conduct sub-accounts need to be developed – something that WHO has taken the responsibility for doing so far, sometimes in collaboration with other experts in the field. In addition to developing the methodology, technical assistance will be needed in some countries. Some of the initiatives/programmes have economists that could assist in this.

Closely linked to developing and using sub-accounts, there are several challenges facing NHA efforts, including e.g. developing an in-country technical capacity (as strengthening national capacity to collect and analyse data is essential), having NHA produced as part of an integrated, routine data system that is maintained for policy use, integrated into the HIS, and developing a global standard methodology. One of the factors holding back M&E as well as planning and quality improvement in health care is the lack of consistent data sets and fragmented and poorly developed information systems. A problem highlighted in this study is that today too many data collection methods exist and standardised low cost methods are needed. If HIS can be better coordinated much would be gained - something the HMN is aiming at.

Sida works from a perspective that health systems play an important role in diminishing the health problems of the poor, through promotive as well as curative and preventive interventions. Extending the coverage of basic health services to the world's poor in areas such as sexual and reproductive health and health and rights, child health and immunisation would save millions of lives each year. It would also reduce poverty, spur economic development and promote global security. Sub-accounts can definitely assist in giving a clearer picture of what is being spent on specific interventions, as well as evaluating outcomes of e.g. additional resources spent.

Based on this study, we may conclude that sub-accounts are useful because they provide detailed information not only for national policy makers but also for global initiatives/programmes focusing on a certain area of the health sector. A main feature of sub-accounts is that they can contribute effectively to the objective of policy and strategy development in specific areas. Being able to manage resources for specific interventions are becoming increasingly required. Users of NHA find it important to answer questions like how funds are organised for specific priorities, the burden on households and governments, whether funds provided are sufficient etc. Sub-accounts also highlight the specific interests and are in that sense sometimes more policy relevant, e.g. for policymakers making decisions at lower levels in the health sector and geopolitical accounts provide specific information needed. Moreover, in the era of MDGs specific information on health priorities are needed more than ever.

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Glossary of Terms

Additionality: The concept that new funding for health resources is additional to,and not a substitute for, funds already available for health. The net, rather than the gross, impact after allowances have been made for what would have existed in the absence of the intervention.

Bilateral donation/funding: Financial resources provided directly by a donor country to an aid recipient country without being passed through a third party organization.

Budget: Quantitative plan of activities and programs expressed in terms of assets, liabilities, revenues, and expenses. An estimate of revenue and expenditures for a specific period.

Data: Factual information.

Developed country: A nation that has achieved (currently or historically) a high degree of industrialization and that enjoys the higher standard of living made possible by wealth and technology. There is a strong correlation between this status and having democratic institutions.

Developing country: A low- or middle-income nation having per capita gross national product (GNP) and/or income thresholds below a specific level. A nation that has not achieved a significant degree of industrialization relative to the size of its population and that has a low standard of living. There is a strong correlation between this status and high population growth. The term is used for countries that are in the process of developing, but is often also used, euphemistically, for countries that are not.

Direct feed: Digitized, factual information coming straight

Donor: Person or entity that gives or bestows a benefit on another; a giver.

Health expenditures: All expenditures for activities whose primary purpose is to restore, improve, and maintain health for the nation during a defined period of time

Monetary resource(s): Money, cash; cash resources.

Mulilateral donation/funding: Flows of resources from a number of entities that are channelled via an international organization active in helping countries develop their economies and raise their standards of living.

National Health Accounts/National Accounts: The framework for which countries' estimates of spending for health care are constructed. The framework can be considered a two-dimensional matrix having health care providers or products that constitute the health care industry along one dimension, and sources of funds used to purchase this health care along the other dimension. Also, accounts used to trace all the resources that flow through the health system over time and across countries.

Nongovernmental organization (NGO): A private, not-for-profit organization that operates exclusively in one country (national NGO) or in more than one country (international NGO).

Recipient: An entity receiving funds – e.g., a developing country's government, a national NGO, or a donor's field office in a developing country.

Appendix I

Questionnaire for evaluation of how health expenditure data fits into Global Health Initiatives

Global Health Initiatives are in this study defined as common, global efforts to support specific areas of health or diseases that affect a large part of the world population.

1. Which organisation do You work for?

1. ☐ UNAIDS
2. ☐ UNICEF
3. ☐ UNDP
4. ☐ WHO
5. ☐ World Bank
6. ☐ USAID
7. ☐ OECD
8. ☐ EUROSTAT
9. ☐ Donors/ Funding agencies……
10. ☐ Consulting Firms (please specify) ……
11. ☐ Networks (please specify)……
12. ☐ Research Institutions/Universities (please specify) ……
13. ☐ Other (please specify) ……

2. Which of these global initiatives best represent Your work?

1. ☐ The Global Fund for AIDS TB and Malaria
2. ☐ HIV/AIDS resource tracking
3. ☐ Roll Back Malaria
4. ☐ Stop TB Partnership
5. ☐ Global Alliance for Vaccines and Immunization
6. ☐ International health resources tracking/ External resource tracking
7. ☐ Child Survival Partnerships
8. ☐ Mental health
9. ☐ Resource tracking for the elderly
10. ☐ Resource tracking for Research Initiatives in health
11. ☐ Other (please specify) ……

3. What kind of data and sources of data are currently used for monitoring and evaluation (M&E) activities in Your organisation? ……
……
……
……
……

4. How would You rate the relevance of using health expenditure data in Your organisation (either total health expenditures and/or expenditures for a specific priority)?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Very low Very high

5. To what extent do You currently use health expenditure data for M&E purposes in Your organisation?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never Always

6. If, and when, using health expenditure data for M&E purposes in Your organisation, to what extent do the following aspects constitute a problem/limitation? (mark appropriate level for each aspect)

	No problem				Major problem
1. Availability of data	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Coverage/breakdown of data	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Regularity of data	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Relevance of data	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Quality of data	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Timeliness of data	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Comparability across countries	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Other (please specify)					
……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. Are You familiar with National Health Accounts (NHA)?

☐ YES

……

☐ NO

8. If yes, do You use NHA within Your organisation?

☐ YES, please specify in what way.

☐ NO

9. In Your opinion, which are/would be the potential advantages of using NHA in Your activities?

1. ☐ Traces the use of funds
2. ☐ Shows spending on different health services
3. ☐ Increases transparency
4. ☐ Tracks health expenditure trends
5. ☐ Facilitates comparisons between countries
6. ☐ Identifies gaps for resource needs
7. ☐ Contributes to efficient allocation of resources
8. ☐ Provides no advantage for our activities
9. ☐ Other (please specify)

10. Any additional comments ……

……

……

……

……

Appendix II

Follow-up questionnaire for evaluation of how health expenditure data and NHA fits into Global Health Initiatives

1 a. Does Your organisation/program currently have an internationally comparable database on expenditures?

☐ Yes
☐ No
☐ DonSection 1 t know

1 b. If yes, is this publicly available?

Yes (where? Please provide a link, if on web)

.....

☐ No
☐ DonSection 1 t know

2 a. Does Your program currently have standard guidelines to compile an internationally comparable database?

☐ Yes ☐ No

2 b. If yes, are these compatible with National Health Accounts?

☐ Yes
☐ No
☐ Dont know

2 c. If no, would Your program be interested in having standard guidelines to compile an internationally comparable database?

☐ Yes
☐ No
☐ Dont know

3. How important is it for Your program to know the sources of funding for your program in any given country? (mark appropriate level for each source)

	Not important				Very important
1. General government	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Social Security expenditures	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Private health insurance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Non Governmental Organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Out of Pocket	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. External resources	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

.....…….....

4. Does Your program currently track any of the above (or other) sources of funds in any given country? Please tick the sources You are tracking

1. General government ☐
2. Social Security expenditures ☐
3. Private health insurance ☐
4. Non Governmental Organisation ☐
5. Out of Pocket ☐
6. External resources ☐
7. Other (please specify) ☐

.....

5. How important is it for Your program to know how much of total health expenditures by different sources is being spent for other programs in the health sector in a country?

	Not important				Very important
1. General government	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Social Security expenditures	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Private health insurance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Non Governmental Organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Out of Pocket	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. External resources	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Other (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

.....……

6 a . Is it important for Your organisation/program to track whether there is efficient allocation of health resources?

☐ Yes ☐ No

6 b. If Yes, could You please rate the importance of the following options?

	Very low				Very high
1. Allocations between resource costs (salaries vs. material expenditure (drugs etc.) vs. capital expenditure)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Allocations by provider categories (hospitals vs. primary care facilities)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3a. Allocations by functions (inpatient vs. outpatient care)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3b. Allocations by functions (curative vs. preventive care)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4a. Allocations by population groups: by income categories	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4b. Allocations by population groups: by gender	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4c. Allocations by population groups: by age	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4d. Allocations by other population groups please specify: ----------	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Allocations of expenditures at district level or other geopolitical levels	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Other, please specify: ----------	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7 . If the information on expenditures for inpatient vs. outpatient care is important to Your organisation/program, please specify the level at which this information will be useful; (if no skip to question 8)

7 a. At the broad level only? (inpatient vs. outpatient) Yes No

7 b. At the level of inpatient or outpatient for specific diseases (e.g. HIV) **or subgroup** (e.g. child)? **Please specify the levels and subgroups of Your interest**

.....
.....

8. Please list 5 important indicators that you would like to track for health expenditures under Your program. (e.g. Health expenditures on malaria as % of total health expenditures, government expenditures per capita for child health programs, expenditures for preventive care for HIV/AIDS as % of total health expenditures for HIV AIDS etc.)

1. .....
2. .....
3. .....
4. .....
5. .....

9. Any additional comments?

.....
.....
.....
.....

Appendix III

Monitoring and evaluation in global health initiatives

Monitoring is the routine process of tracking inputs and outputs. It can provide information on whether an intervention is on track or on budget, or whether it is reaching the desired number of individuals. These outputs are then used to measure whether the desired results or objectives have been reached. This is where evaluation comes in, for example, to reduce the impact of HIV/AIDS on children, outputs must produce changes in childrenSection 1 s lives by increasing food security among vulnerable households. Evaluation assesses the effectiveness of an ongoing program in achieving its objectives.

Monitoring and evaluation enhance the success of global initiatives by establishing clear links between past, present and future interventions and results. Monitoring and evaluation can assist to extract, from past and ongoing activities, relevant information that can subsequently be used as the basis for programmatic enhancements, reorientation and planning. Without monitoring and evaluation, it would be impossible to determine if work was going in the right direction, whether progress and success were obtained, and how future efforts might be improved.

A study evaluating health data resource collection conducted by the RAND corporation was published in 2005 (Eiseman and Fossum 2005). The study was partly based on interviews with key people managing and operating health resource data collections. The findings were that the collections are not always complete, not always accurate and often not timely and detailed enough. The report presents the major existing health resource data collections tracking resource flows and discusses the possibility to create a global health resource tracking system that could be used by all parties providing resources to improve health in the developing countries, i.e. developing countries, developed countries, international organisations, corporations and private not-for-profit organisations. The ideal system should integrate all cash and in-kind resource flows in a timely and effortless manner. The measures that should be used according to the authors for the tracking system are unobtrusive measures. The most common modest measure is in the report defined as the running record that a government or other creates as routine business is going on. A recommendation from the study is that an expert group should be created as to develop technical specifications for a new resource tracking system. Questions that should be considered are what kind of additional data is needed, what are the advantages and disadvantages with different collection methods etc.

Appendix IV

Important indicators to track for health expenditures under global health programmes

HIV/AIDS	
	Health expenditures on HIV/AIDS as % of total health expenditures
	Expenditure for preventive care on HIV/AIDS as % of total health expenditures for HIV/AIDS
	Expenditure for curative care on HIV/AIDS as % of total health expenditures for HIV/AIDS
	Government expenditures for HIV /AIDS prevention
	Government expenditures for HIV /AIDS treatment and care
	Government expenditures for HIV /AIDS prevention for young people
	Household expenditure on HIV/AIDS as a % of total household expenditures on health
	Private spending on HIV/AIDS as % of total private expenditure on health
	Health expenditures on HIV/AIDS by public vs. private providers
	Health expenditures on HIV/AIDS by inpatient vs. outpatient care
	External expenditures on HIV/AIDS
	Out of pocket spending on HIV as share of total HIV spending
	Donor spending on HIV/AIDS as % of total donor spending on health in the country
	Annual per capita expenditure on HIV/AIDS
	AIDS care and treatment expenditures as % of total AIDS health expenditures
	AIDS prevention expenditures specifically directed to the “Most at Risk Populations” (MARPs) as % of total AIDS prevention expenditures
	Non-health expenditures (incl. health related or items of memorandum) as a ratio to the AIDS health expenditures
Malaria	
	Health expenditures on Malaria as % of total health expenditures
	Government expenditures on Malaria
	External expenditures on Malaria
	Out-of-pocket expenditures on Malaria
	Country expenditures on malaria prevention
	Country expenditures on malaria treatment
	Malaria (Per capita and inpatient/outpatient)

	Expenditures for malaria prevention as % of total expenditures on malaria
	Household expenditure on Malaria as a % of total household expenditures on health
	Private spending on Malaria as % of total private expenditure on health
	Donor spending on Malaria as % of total donor spending on health in the country
	Total spending on malaria disaggregated by income quintiles
TB	
	Health expenditures on TB as % of total health expenditures
	Government expenditures on TB
	External expenditures on TB
	Out-of-pocket expenditures on TB
	Country expenditures on TB prevention
	Country expenditures on TB treatment
	Household expenditure on TB as a % of total household expenditures on health
	Private spending on TB as % of total private expenditure on health
	Donor spending on TB as % of total donor spending on health in the country
Mental Health (MH)	
	MH expenditure of total health expenditure
	Mental hospital expenditure of total health expenditure
	MH (Per capita and inpatient/outpatient)
Reproductive health, child health	
	Government expenditures for family planning services
	Government expenditures for reproductive health services
	Expenditures on family planning and reproductive health by public vs. private providers
	Expenditures on family planning and reproductive health by inpatient vs. outpatient care
	Health expenditure on children as % of total health expenditure
Other	
	Percentage of health care in national budget
	Health expenditure as % of public sector expenditure
	% of total health expenditure that is ODA
	Capital versus recurrent health spending
	Capital and large cities versus rural areas
	Drugs versus psychosocial interventions
	Long-term versus short term care in hospitals
	Country expenditures on commodities and products
	Total spending on health insurance with number of people covered
	Total spending on pharmaceuticals as share of total health spending
	Total public spending on health as percent of GDP
	OOP expenditures as % of total health expenditures
	Health expenditure on public health, health promotion, PHC, disease prevention intervention as % of total health expenditure

	Prepayment ratio in total health expenditure
	Health expenditure on evacuation to Europe or America as % of total expenditures
	Health expenditure on salaries for temporary workers
	Health expenditure on social infrastructures (e.g. hospitals)
	Per capita health expenditures by
	a) government
	b) households
	c) Non-Profit Institutions serving Households (NPISHs)
	Local authorities

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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