A STUDY ON THE USE OF NATIONAL HEALTH ACCOUNTS FOR POLICY-MAKING IN THE PACIFIC ISLAND COUNTRIES – WITH RECOMMENDATIONS FOR ADVOCACY AND CAPACITY-BUILDING

(2010)
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This study was prepared by Dr Penny Allbon, Director of the Australian Institute of Health and Welfare in Canberra, a member of the consortium. The study is based on a review of relevant written materials as well as consultations and observations during the period of the third and fourth county workshops in the three project pilot countries, namely the Federated States of Micronesia, Fiji and Vanuatu, as well as the second regional workshop in Nadi, Fiji (24-28 May 2010). The observations and recommendations were developed in close collaboration with the national consultant, Mr Sunia Soakai.

Participants from 13 Pacific island countries participated in the regional meeting in Nadi, Fiji organized by the ADB-WHO project, at which results of the study were shared and additional feedback was provided.
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INTRODUCTION

This study examines how policy-makers have used national health accounts (NHA) and the key factors that determine the extent to which NHA have affected the policy process in the PICs context. It then recommends strategies to address the key issues found to affect the use of NHA for policy-making: in particular, improving awareness and acceptance of NHA across governments and continuously improving technical capacity.

The study encountered a strongly stated commitment to the development and use of NHA across the Pacific island countries (PICs). Supporting statements were made at ministerial level, by Directors-General as well as senior officials.

While not many Pacific countries have fully developed NHA, there has been some experience in the use of NHA for policy-making. As of the early part of 2010, Pacific countries were in various stages of NHA development as follows: NHA developed and institutionalized in Samoa and Tonga; NHA system developed but with the institutionalization process still underway in Fiji, the Federated States of Micronesia, Papua New Guinea and Vanuatu; preliminary NHA data assessment and planning of activities in Kiribati and Tuvalu; one-round NHA estimates produced but no follow-up activities in Palau; and NHA under discussion in the other remaining countries.

More specifically this paper responds to the following terms of reference:

(1) Explore if improved availability of health expenditure data has contributed to evidence-based policy-making in the Pacific.
(2) Describe the status of awareness about NHA in the Pacific.
(3) Recommend advocacy strategies to sensitise NHA and their integration in health sector policy development and policy use in the Pacific.
(4) Identify research areas to promote NHA demand and use.
(5) Identify the key issues to be resolved for NHA capacity building for policy and advocacy work.
(6) Propose a related capacity building plan for use of NHA in health sector policy development.
EXPERIENCES IN THE USE OF NHA FOR POLICY IN THE PACIFIC

At this early stage of development only a few Pacific island countries have reliable health expenditure databases from which to draw policy evidence. Samoa and Tonga have several years of experience in compiling and using the accounts while some countries have no current plans. The ADB/WHO project for strengthening national health accounts in the Pacific trialled health accounts in three more Pacific island countries – the Federated States of Micronesia, Fiji, and Vanuatu.

Evidence-based policy-making means that, wherever possible, public policy decisions should be informed by careful analysis using sound and transparent data. (Scott, 2005)

More specifically, evidence-based policy has been defined by Scott as the systematic and rigorous use of statistics to:

- achieve issue recognition
- inform programme design and policy choice
- forecast the future
- monitor policy implementation
- evaluate policy impact

Samoa and Tonga have compiled NHA information using a two-yearly cycle commencing in the 2001-02 financial year. In both these countries data from the NHA has been used in recent years as evidence to support decision-making. While it is unclear to what extent certain decisions were wholly dependent on the analysis of NHA data, it is certainly true that the data has been used to good effect in providing an evidence-base to argue for change.

In Samoa, NHA were introduced as a policy tool to inform health policy and planning during a time when a health sector reform programme was being implemented in Samoa. One of the objectives of the reform was to “redefine the role of government and health sector stakeholders in the financing, provision and regulation of the health sector”. NHA were used as one of a suite of policy tools to allow the necessary analysis to be undertaken.

Analysis of the NHA information on allocation of health funding by function in Samoa led to a decision to change the balance between primary care and hospital treatment, and to invest more in prevention – health promotion. The accounts showed that although health promotion and prevention of disease was a priority for government, most of the Ministry of Health budget was allocated to the curative, treatment and rehabilitation areas of health care. According to the Samoa Health Sector Plan, 2008-18, only 6% of funding was devoted to health promotion and prevention of disease.

Some of the measures now being taken in Samoa based on this finding include the introduction of the Tobacco Control Act 2008, the introduction to Parliament of a public health bill and the finalization of a noncommunicable disease policy.

Another outcome of the analysis of funding by function in Samoa was a decision to strengthen partnerships with nongovernmental organizations that provide health services (such as the Samoa

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Diabetes Association, HIV/AIDS Association and Family Planning Association) because clients needs are served directly, there would be less pressure on hospitals and more efficient and effective services provided.

NHA were also used extensively to inform a review of the financing of health services in Samoa, which looked at alternative ways to finance health care. The review assessed the viability of a health insurance scheme, with the result that a proposal from the National Provident Fund was approved but has been put on hold “given other commitments”.

The compilation of the accounts also facilitated an examination of expenditure on pharmaceuticals in Samoa, and this led to the development in 2008 of a policy for the more efficient use of medicines, covering importation, distribution, sale, monitoring of pharmaceuticals.

Again in Samoa, the accounts facilitated a detailed examination of how much it costs to send patients overseas for treatment. The result was a decision in 2008 to set up a CAT scan unit within Samoa.

The Government of Tonga has also made good use of NHA information to influence its health policy and financing decisions. Without the NHA findings, Ministry of Health officials believe they would not be in a good position to be aware of what the Government and the Ministry of Health actually spend on Health, the level of public and/or private spending and also the development partner’s contribution to health service deliveries. The findings have revealed important policy issues that need to be explored. According to Tongan health officials, this has included:

- Analyzing the institutional framework and finalizing the Health Care Financial Policy.
- Exploring the ultimate option to increase the Ministry of Health revenues.
- Improving the efficiency of hospital services.
- Review of resource allocation between curative and preventive health service.
- Realignment of resources to combat the increasing event of noncommunicable diseases.
- Better coordination of donor support and others.

The Tonga Ministry of Health constructed a NHA sub-account for non-communicable disease in 2005/06. It led to better co-ordination of non-communicable disease spending with donors and an increased allocation from government budget to prevention.

In both Tonga and Samoa, the NHA findings were instrumental in conducting a review of out-of-pocket expenditure on outpatient and inpatient fees. In Tonga, a revised fee schedule was approved and implemented from 1 February, 2009.

A further outcome of NHA analysis in both Samoa and Tonga has been the increased focus on the level of out-of-pocket spending on traditional healers. As a result, Tonga has made a policy decision to regulate and control traditional healers, through the establishment of a new Association. Similarly in Samoa, the traditional healer system has been formally recognised and efforts made to better regulate the sector.

It is reasonable to conclude that the investment in NHA development in both Samoa and Tonga has created an environment where there is a strong focus on understanding expenditure patterns and that this in turn has made a strong contribution to policy.
In the Fiji islands, production of the first round of national health accounts did not contain very comprehensive information however it was sufficient to enable a focus on the out-of-pocket expenditure component. Using the out-of-pocket figures in discussions at the national level helped to influence decision makers to aim to increase health expenditure by 0.5% of GDP every year. Health expenditure figures used in the report were also used as a basis for justification for the increase in expenditure. The same results were used to influence the ministry of finance to agree to an increase in tobacco tax with the revenue to be invested directly into cardiovascular-related activities rather than all funds being invested into general revenue.

There is as yet little evidence in other Pacific island countries that NHA information contributes to policy analysis. In Vanuatu, for example, the presentation prepared by the Ministry of Health to the Honourable Sela Molisa, Minister of Finance and Economic Management and Chairman of the Ministerial Budget Committee for the 2009 Budget made no reference to evidence from NHA. The presentation for the 2010 budget did graph health expenditure as a proportion of total government expenditure from 1998-2010, although not sourced from NHA data.

However even the process of capturing the data has led to a much better understanding of the health system and expenditure trends. In the recent development of pilot NHA in Vanuatu through the ADB/WHO project, it was a very challenging but useful task for health officials to try to piece together information from many sources to produce complete data – for example on the health workforce, on donor funding, on private sector providers, on pharmaceutical expenditure and of course to get reliable information on out-of-pocket spending. To collect all the data required, it was necessary to work with other government and private sector organisations, and in the process to gain a better understanding of the whole health system, rather than just government budget part. Without the challenge of piecing together the information for the NHA, this broader understanding was unlikely to be gained.

Another example from Vanuatu where the process of compiling information for the NHA has contributed to policy improvement is in the compilation of information on donor funding. As a result of poorly developed financing systems and the desire of many donors for direct accountability for their funds, there is no overall record of how much donors are spending, and where that money is being used.

The compilation of this information also led to a finding that about 99% of donor funding in Vanuatu is spent on preventive health programmes, rather than being distributed across the various parts of the health system.

These findings have highlighted the need to maintain efforts to co-ordinate donor assistance, and ensure it is used for local health priorities. A coordinated approach is now under development in Vanuatu. Similarly, analysis of the Samoan NHA also showed that a large proportion of disease prevention and health promotion is funded by donor agencies, raising issues of sustainability and priority setting.

In other countries there is a growing recognition that the availability of comparisons, made on a standard basis, can provide good evidence to understand how countries differ and how things have changed over time.
PROMOTING NHA IN THE PACIFIC

The level of awareness in PICs

Various NHA activities of the WHO and other international agencies over the last decade have contributed to raising overall awareness about NHA in the Pacific.²

Initial NHA activities were carried out as early as 1998 in Samoa and Papua New Guinea. From 2000 to 2007 representatives from PICs attended various international NHA meetings, seminars and training workshops in Vermont (USA), Bangkok (Thailand), Auckland (New Zealand), New Delhi (India), Seoul (Republic of Korea) and Sydney (Australia). In 2005, a web-based online NHA Training Course was introduced in the Pacific Open Learning Health Network (POLHN). During 2006-2007, WHO supported NHA pilot projects in the Federated States of Micronesia, Fiji and Vanuatu. In 2008-2009 Pacific participants attended the series of consultation meetings on the revision of the System of Health Accounts, the international standard for health accounting, conducted in Shanghai (China), Seoul (Republic of Korea) and Nadi (Fiji). In 2009-2010 the ADB-WHO Pacific NHA project organized two regional meetings on NHA specifically for PICs.

Thus, while there has been a significant level of awareness about NHA in almost all the Pacific island countries for some time now, actual NHA implementation has reached advanced stages in only a few countries. Many of the Pacific countries still need to be convinced about the importance and usefulness of NHA, and to eventually invest in establishing NHA. The rest of this section suggests strategies for advocating use of NHA and identifies areas of research whose results can be used for advancing NHA advocacy work.

Advocacy strategies

The best advocacy for the use of NHA in policy development is to demonstrate their practical usefulness.

This message needs to be received not just by health sector officials, but by policy-makers across government including at a political level.

There are risks in doing this too early. Advocacy may set the cause backwards unless there is a sufficient level of skills and experience in compilation to back up the advocacy (this can be assisted by the availability of consultant advice). It may also fail if stakeholders are able to identify obvious inaccuracies in the accounts once they become familiar with them. Compiling NHA is not a simple task, and getting the numbers right can take many years of development and experience.

Once there is a reasonable level of technical expertise and a good understanding of how the accounts have been compiled within a country, the production of a short summary of the key messages drawn from analysing the findings in comparison to other countries, and over time, would be a useful catalyst to encourage policy discussion across government and potentially in the community.

Useful strategies include:

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- production of regular reports containing the key messages in easily-digestible format;
- running workshops for stakeholders across the health services and other areas of government to build an understanding of health accounts as a tool for policy analysis (see later for more detail);
- using the media by publishing easily-read top line results, including some explanation of interesting features;
- using existing forums, such as the Pacific Senior Health Officials (PSHON) forum, which is co-coordinated from the Australian Department of Health and Ageing, to present information on the accounts and their usefulness – including in the PSHON newsletter; and
- keeping regional stakeholders well informed about the accounts and their usefulness (such as the Secretariat of the Pacific Community, the Pacific Forum, meetings of regional health Ministers, regional universities and all aid agencies working in the countries).

**Research and analyses to promote NHA demand and use**

Good policy requires good statistics at different stages of the policy-making process, in ‘upstream’ stages of policy-making, such as issue recognition, programme design, policy choice and accurate forecasting.

The analysis of national health accounts allows many aspects of the complexities of a health system to be explored, particularly by examining trends over time, and comparisons with other countries in the region.

A useful place to start in promoting research based on NHA is to demonstrate their usefulness as an evidence base for determining progress towards key policy objectives. The WHO has recently articulated a set of policy objectives and Indicators for the allocation of health system resources in its *Health Financing Strategy for the Asia Pacific Region, 2010-2015* (referred to as *WHO Health Financing Strategy*).

Achieving universal access to coverage of quality health services without excessive household financial burden is a widely recognised objective in the Asia Pacific region (*WHO Health Financing Strategy*). Governments are also committed to providing services that are based on the values and principles of primary health care. Achieving these objectives needs a strong and informed government role backed up by good evidence. The information contained in health accounts will help government analyse their health financing situations and identify the actions they need to take to achieve these goals.

In its Strategy, WHO proposes a number of target indicators to monitor and evaluate progress. The first two of these are:

1. Out-of-pocket spending should not exceed 30%-40% of total health expenditure.
2. Total health expenditure should be at least 4% - 5% of the gross domestic product (GDP).

The routine preparation of national health accounts will allow government to measure themselves against these target indicators.

Another key benefit of the introduction of NHA which needs to be emphasised is the visibility it gives to financial information other than expenditure from government budget. Health policy and financing decisions need to be made in the light of evidence which includes information about the formal private health sector, nongovernmental organizations, out-of-pocket expenditure and the traditional health sector.
Some of the key indicators of health sector policy that can be derived by analysis of NHA information include:

- Level of out-of-pocket spending by individuals.
- Level of government spending.
- Total health expenditure as a percentage of GDP.
- Balance between government and external donors.
  - Examining the pattern of health accounts across Pacific island countries reveals some quite striking differences in the percentage of health funding that comes from external sources. For example in Fiji in 2006 only 1.9% of total health expenditure was financed from external sources. In the Federated States of Micronesia, however, more than 60% of health funding came from outside donors.

- Where donor funds are concentrated.

- Whether spending is distributed fairly across regions.
  - Examining the distribution of expenditure between urban and rural regions, and across different islands/states or regions can reveal some interesting unintended results and lead to changes in policy.

- What share of funding is allocated to primary care.
  - Most essential care (80%) and most desirable health interventions (70%) can be delivered at the primary care level, according to a review commissioned by the WHO in 2005.

- What is the balance between spending on prevention and treatment.
  - For many Pacific island countries stopping the rising tide of chronic non-communicable diseases is a major priority of the health system. Here again, NHA assist in monitoring the funding needed to increase preventive care for chronic diseases, such as diabetes. Currently, most spending is used to manage and treat the complications of diabetes. Yet we know that early detection and community management is more cost-effective.

- Monitoring efficiency and performance.
  - The information contained within NHA is also able to be analysed to contribute evidence to Public Expenditure Reviews and to project health financing requirements into the future. Some of the research topics which Pacific island governments have undertaken in relation to efficiency include the cost of pharmaceutical supplies and the relative costs of overseas treatment versus local investment in new infrastructure, such as the investment in a CAT scan unit in Samoa.

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3 WHO Western Pacific Region and South-East Asia Region. 2005. Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006-2010).
Health accounts information can be combined with other information such as disease data, or more detailed financial data, to produce a wide range of analyses. In this way, it allows for complex analysis to be undertaken of many aspects of the health system. The disease costing database developed in Australia, for example, provides a comprehensive source of information on expenditure for various diseases, broken into the type of health service accessed.

Similarly, health account information can be used in combination with survey data, such as the rate of maternal mortality, to assess and compare the outcomes that are achieved for particular levels of expenditure.

In these ways, NHA form a fundamental building block towards a broader understanding of the health system.

NHA CAPACITY-BUILDING FOR POLICY AND ADVOCACY WORK

Key issues

This section identifies key issues to be resolved for NHA capacity building for policy and advocacy work. Building capacity to understand and analyse health accounts and their implications for policy use deserves attention in its own right, as the skills and experience needed are not the same as those needed to compile health accounts.

In his work on the use of statistics for evidence-based policy-making, Scott (2005) describes a Vicious circle, where statistics are weak and policy-makers make little use of them. Evidence-based policy-making is not practised which results in poor policy decisions and poor development outcomes. In vicious circle countries, weak production and funding of statistics coexists with weak use of statistics. To break this vicious circle, Scott concludes that it is necessary to adopt measures which will simultaneously increase both the demand and supply of statistics, as well as improve the dialogue between producers and users of data.

The existence of a strong champion for the development and use of health accounts will provide a major impetus towards development of the capacity to integrate the accounts into policy. Potential champions need to be identified and fostered in each country – whether they are Ministers, Directors-General or officials.

In those Pacific island countries where compilation of the accounts has been progressed, three factors were identified which limit capacity.

First, there is a shortage of policy analysts with the combined skills and experience to understand the accounts at the broad level to be able to draw the analysis from them. This requires a particular set of skills, different to the more detailed compilation of the numbers.

To be able to analyse the accounts for policy evidence, policy analysts need a broad understanding of the accounts themselves – where the information came from and how it was put together – in order to be able to mine it successfully to find the answers to policy questions. However they also need to have a broad policy background, to know what kind of questions need to be formulated and what sort of information to mine from the accounts.

A compounding factor is that in many cases, responsibility for the actual compilation of the accounts falls on the individuals most likely to have the policy capacity, and they do not have the time to devote to the analysis.
The second limiting factor reflects the early stage of development of the accounts – policy makers are not yet sure if they can trust the numbers. There is a high level of risk attached to developing policies on the basis of evidence that may not be reliable. As the Director-General of the Vanuatu Ministry of Health said, “I need to know that the numbers can be relied on”.

A particular concern that needs to be resolved in relation to the reliability of the numbers is the difference between various versions of the NHA accounts, as published by the countries themselves and by WHO. In some cases, these differences are quite marked and there is no readily available explanation as to what causes the differences. For example, the Tonga report states that health spending as a share of GDP was 6.8% in 2005-2006, a gradual increase from 6.1% in 2001-2002. Yet the WHO data base, and many reports which use that data base, assert that total health spending in Tonga was below 5% of GDP, e.g. see WHO 2005.

The differences in the numbers need to be sorted out as there is a risk of confusing all stakeholders and reducing the level of trust in and usefulness of the accounts. “Unannounced and inadequately explained revisions to a statistical series can unsettle policy-makers by creating uncertainty. Consequently, the process by which revised statistics are published and disseminated may be as important as the revised figures themselves” (Scott, ibid.)

A third limiting factor is that there is not yet widespread knowledge and understanding about health accounts across health personnel, including health service managers, nor across the other relevant areas of government.

In the main, knowledge about the accounts is still mostly restricted to health financial units. By way of example, a senior finance manager in Vanuatu realised that if he briefed the Minister on the basis of information in the accounts, the Minister would be likely to ask the views of other key stakeholders – including clinicians – and they may not endorse the approach or the findings unless they were broadly familiar with the accounts and their usefulness.

At a number of the workshops held in the pilot countries during the ADB/WHO project, there was evidence that this understanding is growing across other key personnel. The formation of Steering Committees to oversee the compilation of the accounts has been a very useful strategy to achieve broader ownership.

**Capacity-building plan**

To address the key issues identified, this section proposes a related capacity-building plan for the use of NHA in health sector policy development, in collaboration with regional NHA institutions and network.

Building capacity to understand and analyse health accounts and their implications for policy use deserves attention in its own right. The skills and experience needed are not the same as those needed to compile health accounts.

Firstly, it should be recognised that developing a culture of evidence-based policy-making is a slow process which will take years (see Scott, ibid).

The World Bank NHA institutionalization case studies (unpublished) found that the successful cases in Asia (and most were in Asia) involved time periods of 10-15 years for capacity-building. The reality is: it takes a long time.
Over time, capacity to analyse the accounts and use them will expand as the skill base in compiling the accounts broadens and awareness increases. However, assistance can be provided to build up the capacity to understand and use the accounts both within health departments and across governments more broadly.

The NHA provide the supply side of information, while the demand side comes from policy-making. Building capacity involves the adoption of measures to increase both the supply and the demand for statistics, as well as to improve the dialogue between the producers and users of data.

Drawing policy inferences out of evidence is a learned capacity, which is best fostered in an environment where it is happening routinely. Development of the capacity to analyse health accounts and actually use them in making policy decisions is not just an academic exercise – it will be fostered by the experience of operating within a government environment.

The benefits of basing a programme of assistance in an institution with a solid base of expertise and an ongoing responsibility for evidence-based policy cannot be over-emphasized. There are many examples where fledgling partnerships have proved unsustainable. For example, the Institute of Health Policy (IHP) – one of the partners in this project consortium – tried for two years to find a suitable partner in the Pacific island countries. During that search, IHP did sign up partners, only to have them drop out (including USP and NRI in Papua New Guinea). The usual reasons were lack of a core interest/motivation and appropriate skills in health services/policy research. These are really scarce skills in the Pacific island countries.

Clearly, the best environment in which to foster a stronger capacity to draw on the country’s NHA is the country’s health department, and the optimal timing is during the development phase of the budget cycle. External assistance over this period will however assist by helping to formulate the questions to be asked of the data, and manipulating the accounts to find the answers.

Capacity-building can also be enhanced at non-peak times by policy analysts receiving some training in other governments within the region where health accounts are routinely used and analyzed.

The capacity-building plan proposed here has four main components.

1. Establish a regionally-focused Health Financing Policy Centre

A regionally-focused centre where expertise is available to assist countries during peak budget development time and where learning can be enhanced at other times, would be well placed to boost capacity across the region.

There are two broad alternatives for placement of this Centre. In both cases, the strategic plan and work plan for the Centre would be set by the proposed Network administration – including the Network Steering Committee/Board/Executive Committee (as discussed in other components of this Project).

Option 1 is to locate it with the regional Technical Resource Centre for National Health Accounts, which this Project recommends to be placed at the Fiji School of Medicine (see report on Development of a collaborative network to support institutionalization of health accounts in Pacific island countries: Critical issues and options). Addition of this function would provide additional depth to the proposed Resource Centre by creating a new stream of activity and engaging with countries in a different way.
An alternative (Option 2) would be the creation of a Centre by adding a Pacific learning focus to an institution which is already routinely engaging in the analysis and integration of health accounts into policy and financing decisions. While this Centre should have close links with the proposed Technical Resource Centre for National Health Accounts (and might be co-located with it), there would be recognition that it is different in nature and is developing a different set of skills in a different set of practitioners.

In broad, this concept for a Health Financing Policy Centre is to develop a Pacific arm from a base in a government institution in either New Zealand or Australia where national health accounts are regularly produced and analyzed for their policy implications. Close links would be maintained with the proposed NHA Technical Resource Centre for National Health Accounts.

Strong partnerships would need to be built with Pacific island governments and with universities in the region, including the University of the South Pacific and other country-specific universities. University partners within Australia include the AusAID-funded Health Policy and Health Finance Knowledge Hub at the Nossal Institute for Global Health at the University of Melbourne.

The activities of the Centre would include

- secondment of Pacific island policy analysts into the Centre during non-peak times to gain experience with the accounts, and increase the demand for use of the data;
- in-country assistance from expert consultants during peak budget cycle development to assist in the formulation of questions about health policy and financing that can be answered from analysis of the NHA, and thus influence the analysis and development of policy options;
- assistance to Pacific island health departments in producing policy commentary on NHA for their country;
- assistance to health department officials to prepare and present seminars and workshops to stakeholders across governments (see item 3 below) and development of materials for marketing the use of NHA across all sectors of government; and
- development/updating of advocacy materials.

While fostering the skills required to draw the policy inferences out of national health accounts needs its own particular focus, there is potential for it to be extended to other aspects of evidence-based health policy analysis as well.

In assessing the relative merits of the above two options for the placement of a Centre – either with the technical resource centre or in another institution that routinely builds an evidence base – a decision has to be made about the kinds of individuals who will benefit from the capacity-building.

On the one hand it can be argued that, in practice, while compiling health accounts and drawing policy implications from them are distinct functions, both functions require overlapping sets of skills. In the less developed countries where such skills tend to be scarce, they are most likely to be found in the same place. In Asia, many of the institutions involved in NHA production are also the leading health policy centres in their countries (Thailand, Sri Lanka, China, Bangladesh, Hong Kong, Malaysia, Kyrgyz, etc). However there are some exceptions in developing economies, such as Philippines or Indonesia. The global review of experiences in setting up health policy institutions for the 2007 AHSPR Biennial review on health systems policy research capacity building provides some evidence that a split of functions may not be optimal because of this scarcity of skills.
To date, the countries in the Pacific that have begun using NHA place the responsibility for compiling the figures with the policy analysts who use the figures, e.g. in Samoa, it is the Strategic Planning and Policy Division that has responsibility for compiling the accounts.

Balanced against this concern about overlapping responsibilities are the arguments put earlier that building capacity to understand and analyse health accounts and their implications for policy use deserves attention in its own right, and is best developed as an extension of the skills and expertise that policy analysts need to have in their tool box.

2. **Encourage the development of champions**

A clear element in capacity building that comes out of the World Bank case studies is the importance of NHA champions. Champions are usually driven by the policy usefulness of the accounts, i.e., they articulate and lead the demand side of the development of accounts.

To foster the development of champions, the proposed Centre will have a clear work plan to identify such leaders and to provide opportunities for them to broaden their skills base and their experience at other institutions within the region.

Champions may well be at the Director-General level – for example in Samoa, the Director-General is a vital supporter and advocate for the use of NHA. It will therefore be important that the Centre develops ways of ensuring that high level discussions about NHA are included in forums and newsletters that reach senior officials.

3. **Encourage the presentation of seminars and workshops across health services managers and broader government stakeholders**

The aim of this activity is to market the use of NHA by building an understanding of health accounts as a tool for policy analysis among health service managers as well as key personnel across governments. Better knowledge of the accounts is likely to lead to a stronger demand for their use.

This does not require an in-depth learning about the accounts, and could be achieved by running half day workshops for policy analysts from across relevant areas of government. The purpose of the workshops would be to create a broad understanding of the accounts, from where and how they are compiled, and the kinds of manipulations that are possible. It is assumed that the policy analysts involved in the workshops would already have a capacity for broad policy analysis.

In a practical sense, it would be possible for the core workshop content to be compiled by the proposed Centre, with health accounts specialists in each country tailoring the content to individual countries, with the assistance of the Centre. In itself, this would be a useful exercise for the specialists in each country.

4. **Maintain and increase the effort in training and assisting countries to compile NHA**

Unless the health accounts numbers are reliable and considered trustworthy, policy-makers will not use them for making health resource decisions. Getting the numbers right will take many years of development and requires the systems and the investment to be sustained so that the quality keeps improving until the reliability of the accounts is widely acknowledged.
Here there is something of a chicken and egg situation - if the accounts aren’t actually valued (by being used), there is no real incentive to keep improving them and getting the numbers accurate. Therefore effort is needed on both fronts.

Reliability, accuracy and credibility of numbers really matter in the long run for policy impact. Sponsors sometimes stress the policy message as an avenue into sustainability and argue that obvious errors in the numbers can be ignored and dealt with later. But experience shows that this simply does not happen. If numbers lack face validity or credibility, then the long-term policy impact and use will not happen.

CONCLUSION

Based on the findings of the study, it appears that the demand for the evidence that NHA can produce is growing across Pacific island countries. Where reliable NHA and relevant expertise exists, the NHA are used for at least the first two of Scott’s categories set out earlier; i.e. to achieve issue recognition and inform programme design and policy choice. Further sophistication is likely to be required to deliver the full benefits of NHA in terms of the remaining categories; i.e. forecasting the future, monitoring policy implementation and evaluating policy impact.

The study found that the key factors which influence the extent to which PICs use NHA as an evidence-base are:

- the level of awareness and understanding of NHA within the Ministry of Health and other key government agencies, such as Treasury and Finance;
- the existence of skills which can draw the policy-relevant messages out of the NHA;
- the extent to which such officials perceive the NHA to be reliable – which in turn is influenced by the technical competence of those preparing the NHA; and
- the availability of technical capacity.

Use of the NHA can therefore be encouraged by a range of strategies that address these issues. However it must be recognised that developing a culture of evidence-based policy-making is a slow process which will take years.

Advocacy strategies - including disseminating easily-understood messages from the accounts, using the media, running workshops and presenting to senior officials and regional forums - will increase awareness and acceptance of the usefulness of NHA.

The best advocacy for the use of NHA in policy development is to demonstrate their practical usefulness.

The extent to which NHA are used as evidence can be assisted by creating a regionally-focused centre that PICs can draw on, where a solid base of expertise can develop and where use of NHA as an evidence-base is a routine on-going function. A regional centre should have strong links to government and universities and be able to carry out a range of functions, supported by the proposed network of countries.

Some of the functions of the Centre would include arranging secondment, fostering “champions”, providing in-country assistance with seminars and workshops, and providing assistance to countries in distilling messages from their NHA.

These strategies will all assist in building a culture and a capability where NHA are demanded and used by policy-makers as a reliable evidence-base for reform.