NATIONAL HEALTH ACCOUNTS IMPLEMENTATION IN PACIFIC ISLAND COUNTRIES: THE EXPERIENCES OF PAPUA NEW GUINEA, SAMOA AND TONGA

(2010)

ADB-WHO Project
Strengthening Evidence Based Policy-Making in the Pacific:
Support for Development of National Health Accounts
ACKNOWLEDGEMENTS

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CONTENTS

ABBREVIATIONS ........................................................................................................... i

NATIONAL HEALTH ACCOUNTS IMPLEMENTATION IN PAPUA NEW GUINEA
by Navy Mulou ................................................................................................................. 1

DEVELOPMENT AND INSTITUTIONALIZATION OF NATIONAL HEALTH
ACCOUNTS IN SAMOA by Frances Brebner ................................................................. 11

NATIONAL HEALTH ACCOUNTS IMPLEMENTATION IN TONGA
by Tu’akoi ‘Ahio .............................................................................................................. 27
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHI</td>
<td>Australian Health International</td>
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<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HCFC</td>
<td>Health Care Finance Component</td>
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<td>HRPIRD</td>
<td>Health Resource Planning Information and Research Division</td>
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<td>HSP</td>
<td>Health Sector Plan</td>
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<td>HSSP</td>
<td>Health Sector Support Project</td>
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<td>ICHA</td>
<td>International Classification of Health Accounts</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable Diseases</td>
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<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>NHC</td>
<td>National Health Conference</td>
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<td>NHES</td>
<td>National Health Expenditure Survey</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistics Office</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
</tr>
<tr>
<td>PATIS</td>
<td>Patient Information System</td>
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<tr>
<td>PCE</td>
<td>Personal Consumption Expenditure</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>SDPD</td>
<td>Strategic Planning and Policy Division</td>
</tr>
<tr>
<td>SDS</td>
<td>Samoa Development Strategy</td>
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<tr>
<td>SES</td>
<td>Statement of Economic Strategy</td>
</tr>
<tr>
<td>SHA</td>
<td>System of Health Accounts</td>
</tr>
<tr>
<td>SPC</td>
<td>Secretariat for the Pacific Community</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendants</td>
</tr>
<tr>
<td>TH</td>
<td>Traditional Healers</td>
</tr>
<tr>
<td>THE</td>
<td>Total Health Expenditure</td>
</tr>
<tr>
<td>TOP</td>
<td>Tongan Pa‘anga (currency)</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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INTRODUCTION

Background information

Papua New Guinea, located east of Indonesia, is the largest among the Pacific island countries in terms of population size, estimated at about 6.5 million in 2008. The need to generate and use critical health statistics and information to improve health policy making and, in turn, improve health sector performance in the country has long been recognized by the Government. It was the first among the Pacific countries to start estimating health expenditures comprehensively using a national health accounts (NHA) framework. Work on NHA began in 2000 with the Department of Health as lead and with technical assistance from the Australian Agency for International Development (AusAID) and World Bank. NHA for the years 1998, 1999 and 2000 were estimated. Despite the early start and recognized uses of NHA, however, currently the compilation of the NHA is irregular and the Government is still working on setting up a sufficient and stable institutional base from which to carry out NHA activities on a routine basis.

The issues and constraints experienced during the first round of NHA activities included, among others: (1) the NHA team consisted of government staff temporarily assigned to do NHA work, resulting in low staff commitment; (2) NHA functions and activities were not assigned to any specific office; (3) additionally, because of (1) and (2), there was no systematic transfer of NHA knowledge from staff or NHA team members previously trained in NHA (and who had eventually left) and no mechanism for replacing departing staff or team members; (4) many data gaps were identified but the first round data collection activities to fill these gaps were ad-hoc involving no institutional development and no long-term funding commitment; and (5) institutional links for NHA data collection were generally weak. These are some of the issues that PNG needs to address in future NHA activities.

As mentioned above, the first round of NHA work produced estimates for the years 1998, 1999 and 2000. There were gaps in the estimates as no data was collected for health expenditures of local government (lower than provincial government), private sector employers and nongovernmental organizations (NGO). Some highlights from the first round NHA estimates include the following (Table 1):

• In general, the overall pattern of spending by source (financing agent) had not changed significantly in the three years.
• As a source/financing agent, the Government spent close to 90% of health funds
• Of government spending, about half was paid by national government, about one-fourth by provincial government and one-fourth by donor support
While national government percent share had stayed about the same, provincial government share had declined and donor share had increased during the three years. Overall, the share of government spending had declined slightly.

There were slight increases in the shares of private health insurance and household out-of-pocket spending for health in the three years.

Table 1. Health expenditures by source/financing agent: Papua New Guinea, 1998-2000 (Kina)

<table>
<thead>
<tr>
<th>Source/Financing Agent</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount</td>
<td>%</td>
<td>Amount</td>
</tr>
<tr>
<td>Government</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>107,817,084</td>
<td>39.5</td>
<td>132,388,054</td>
</tr>
<tr>
<td>Provincial</td>
<td>78,797,038</td>
<td>28.9</td>
<td>77,901,760</td>
</tr>
<tr>
<td>Local</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign assistance</td>
<td>60,517,013</td>
<td>22.2</td>
<td>87,568,757</td>
</tr>
<tr>
<td>Total, government</td>
<td>247,131,135</td>
<td>90.6</td>
<td>297,858,571</td>
</tr>
<tr>
<td>Private Sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Churches</td>
<td>820,397</td>
<td>0.3</td>
<td>1,113,617</td>
</tr>
<tr>
<td>Private insurance</td>
<td>1,332,374</td>
<td>0.5</td>
<td>3,540,475</td>
</tr>
<tr>
<td>Private companies</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGOs, other</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household out-of-pocket</td>
<td>23,559,450</td>
<td>8.6</td>
<td>31,226,280</td>
</tr>
<tr>
<td>Total</td>
<td>272,843,356</td>
<td>100.0</td>
<td>333,738,943</td>
</tr>
</tbody>
</table>

History of national health accounts work

It was in the year 2000 when serious discussions commenced on the need for and usefulness of NHA, and consequently NHA development activities began in earnest. This was also the period during which Papua New Guinea’s 2001-2010 National Health Plan was about to be launched by the government. In the initial stage of NHA development the Government was assisted by AusAID and the World Bank.

The demand for health accounts data came about when the Government determined that it needed to review health financing in the country. More specifically, the Government realized that it could not finance health care services adequately, given the limited resources it had at its disposal. The Government could no longer rely on general taxation alone to finance health services, since the Government’s income generating capacity had been slowly eroding. Furthermore, the percentage share of government expenditures going to health had been declining over the last two decades. The level of real per capita government spending on health remained low and government expenditure on health as a percentage of the gross domestic product (GDP) averaged around three percent.

The poor state of the nation’s economy and the high population growth rate both contributed to the persisting low per capita health spending. There was need for the Government to look for and mobilize funds for health from alternative financing sources. It also needed to explore reforms to increase efficiency in the use of limited health resources and to improve the allocation of health funds to different uses.
The approach that the Government took to address the various issues mentioned was to improve information and data (including in particular the production of NHA), and to base health policy and decision making on these data. It was envisaged that the NHA will be a tool that can aid decisions about how health resources including manpower should be allocated to various uses. The NHA and its analysis can provide guidance for identifying health sector reform areas and also be used for subsequent monitoring of both reform implementation and impact. The NHA system is thus a very important tool for the proper and informed implementation of PNG’s ten-year national health plan.

In the first round of NHA activities, the NHA project phase, full estimates were produced for the years 1998, 1999 and 2000. After the project phase ended, only partial estimates were generated for the subsequent years from 2001 to 2008. The latter estimates, although constituting only partial NHA were produced on annually. Overall, PNG still does not have a fully established NHA system, particularly in the institutional aspect, as in the case of some developing countries. In fact this aspect of NHA development has remained in its infancy stage. As of 2009, the Health Economics Unit within the Department of Health continues to undertake the limited scale NHA work in PNG.

INSTITUTIONAL STRUCTURE AND INSTITUTIONALIZATION

In 2000 the NHA team was formed to oversee the implementation of the first round of NHA activities. The team comprised of representatives from central government agencies and an NGO. The central government agencies involved included the Departments of Health, Finance, Treasury, Planning, Defence, Provincial and Local Level Government, National Statistical Office, and the Church Medical Council. It must be noted that the team members participated in NHA activities on a part-time basis only. As full time government workers, the NHA team members had their respective routine responsibilities to attend to aside from NHA work.

The core of the NHA estimation work was carried out by the Health Economics Unit. The Unit’s health economist and a research assistant (the latter hired specifically for NHA) together did the data collection, data processing, and compilation of NHA data. The NHA framework was developed and the first round NHA estimates for the years 1998, 1999 and 2000 were prepared with technical assistance from Professor Alejandro N. Herrin, consultant from the University of the Philippines, School of Economics.

The Health Economics Unit continues to function as the main clearing house for NHA. There are two main reasons for keeping NHA work in the Department of Health. First, the policy relevance and usefulness of the NHA can be ensured if NHA production is housed in the same entity (the Department of Health) that is also the main user of the information. Second, NHA production can be successfully institutionalized (eventually) if and when the policy uses of NHA become established. Currently the Departments of Health, Finance, Defence, Church Medical Council and the Office of the Insurance Commissioner are the offices that provide most of the input data to NHA. Most of these offices have to do additional processing of data from their respective administrative records in order to supply NHA data requirements.

The NHA as of 2009 is still not regularly commissioned by the Government and only partial NHA have been produced for the year 2001 and onwards. The current national health plan requires that all stakeholders in health provide both health statistics and financial data to the Department of Health on a regular basis. This applies to those in the public sector as well as to those in the private sector. However, there is no law or other legal instrument in place that requires these offices to comply. In
contrast, there is a national legislation that requires both public and private entities to provide data to the NSO when requested.

For purposes of NHA work, weak institutional linkages remain between the Department of Health and key central government agencies like the Department of Finance, the National Economic Fiscal Commission, the Department of Provincial and Local Government Agency, and the National Statistical Office. There is an even weaker linkage between the Department of Health and private sector firms, resulting to constant data gaps in the NHA matrix. Various strategies are being adopted by the DOH to improve the situation. These include effective networking with key central government agencies like Treasury Office and the National Statistical Office (NSO). Another is establishing collaboration with private sector firms through the recently implemented Department of Health Public Private Partnership Policy.

Donor partners like Asian Development Bank (ADB), AusAID, the World Bank, World Health Organization (WHO) had been instrumental in starting NHA development and promoting the continuing but limited NHA work. They will play vital roles in future NHA system development activities and in the NHA institutionalization process. These include, among others, the following:

i) Providing technical assistance (NHA expertise) over a span of at least one year to update/revise the NHA framework and methods;

ii) Providing funding for the development of manpower and institutional capacities, and development of data systems; and

iii) Promoting NHA during high level talks between the donor partners and the Government.

There is recognition of the need to institutionalize NHA within the health sector. However, there is still a lack of appreciation by other central agencies of government and the private sector due mainly due to lack of awareness about the importance of NHA for informing policy making.

In summary, the progress of NHA institutionalization in PNG would depend, among others, on developing the following:

i) A strong ownership of NHA by the national government backed up by adequate resource commitments (financial and manpower).

ii) Effective dialogue between the DOH and key central government line agencies like the Departments of Treasury, Finance, Defence, Provincial Affairs, Personnel Management and the NSO – for increased cooperation and better access to data;

iii) Effective dialogue between the DOH and private sector firms, private health care providers, and NGOs – for increased cooperation, particularly in providing access financial data;

iv) A standard government accounting system that is adopted from the national level down to the sub-national levels (provincial and local governments) – to facilitate government health expenditures data compilation

v) Fielding of surveys by the national government, i.e. NSO household income and expenditure survey) on a regular basis.
CAPACITY AND RESOURCES

The first round NHA estimation work was made possible with the support of a temporary, full-time research assistant. This NHA-trained research assistant was not absorbed by the Department of Health and had eventually left after the project (development phase) was over – thus, creating a gap in manpower to support continuing NHA work. Staff positions needed to be created within the Department of Health to fill the gap. The current restructuring of the Department of Health in 2010 will create two additional positions in the Health Economics Unit, one of whom will be fully involved in NHA work.

As of 2009 the Health Economics Unit had only one staff, a health economist. This staff participated in a NHA training workshop in Manila in December 2000 together with the other (original) NHA team members. The purpose of the workshop was to introduce the NHA team to the concepts, definitions and methods of health accounting. The training was coordinated by Professor Alejandro N. Herrin of the University of the Philippines School of Economics, with funding from the World Bank.

NHA development work was carried out within a short time frame and this had drawbacks. The initial activities were intended to develop the NHA framework, to produce NHA estimates and, at the same time, to also build up the NHA knowledge and technical skills level. In retrospect, the initial activities conducted were not adequate to accomplish fully the above objectives; in particular the development of local manpower suffered the most. More time should have been given to learning-by-doing NHA, much more than the time spent for formal training. People’s knowledge and practical skills are enhanced quickly and effectively when theoretical lessons are complemented by extensive hands-on training.

The Department of Health is currently using its own resources to fund NHA activities. So far resources allocated to NHA work have been modest. The bulk of government health funds have gone towards priority health programmes. The present level of resources dedicated to NHA, however, does not in any way mean lack of interest by the Government to continue NHA activities.

CONSISTENCY OF METHODOLOGY

As mentioned previously, the NHA framework was developed during the first round of NHA activities by the NHA team, with technical assistance from a consultant. PNG continues to use the original NHA framework and matrix/design up to the present time in the production of its NHA.

The Department of Health has routine data collection and reporting systems in place. These routine data collection and reporting are part of the Department’s National Health Information System (NHIS). However, the system captures mainly health statistics like hospital admissions and discharges (with detail on diseases, sex, age, bed days and average length of stay of patients), outpatient services utilization (with detail on diseases, age and sex of patients), and more.

The Health Economics Unit thus developed and established various data collection and reporting mechanisms specifically for NHA purposes. For public sector data, data collection was incorporated into the annual Department of Health public sector expenditure reporting. To capture private sector
data, data collection was done through special surveys of stakeholders that operate in the private sector, like insurance companies, large mining and oil companies, and large oil palm estates. Ideally, the special surveys should be done on a periodic basis. A number of problems were encountered in the conduct of the private sector stakeholder surveys and these included the following:

i) Low survey response rate by private sector firms, at around 30 percent, because of lack of awareness about the importance of the surveys;

ii) Inadequate information dissemination and/or awareness raising workshops to prepare and inform respondents about survey objectives and requirements;

iii) Limited funding and manpower to do the surveys.

Data on household spending for health in PNG is collected through the country’s household income and expenditure survey (HIES) conducted by the NSO. However, this survey is not done on a regular basis as in other countries due to the high costs involved and the limited financial resources of government. The last HIES was conducted in 1996 and was conducted in collaboration with an American doctoral student who was working on his dissertation. To address this issue of irregular availability of household expenditures survey data during the first round of NHA work, the consultant and the local staff counterparts formulated an indirect method for estimating household out-of-pocket spending for health – to be applied during the years when HIES data are not available. In the indirect method the proportion spent on medical fees and medicines out of total household expenditures from previous years survey, e.g. proportion taken from the 1996 HIES) is applied to the personal consumption expenditure (or the PCE component of the national income accounts) for the year for which NHA is being estimated, e.g., PCE for 1998.

The illustrative two-dimensional matrix below (Table 2) shows what is being reported in the PNG NHA and these basically consist of information on the sources and uses of health funds in the country. The sources of funds refer primarily to financing agents. The expenditure uses categories in terms of the 10 programme areas in health of the Government. There is incomplete detail by health care functions, i.e. limited breakdown of curative care (inpatient and outpatient), rehabilitative care, long term nursing care and others. There is incomplete detail by health provider, i.e. no breakdown by hospitals, office of physicians, office of dentists and office of other health professionals.

Using the International Classification of Health Accounts (ICHA) as reference, the PNG matrix shows sources of financing categories that reflect the health sector context; but which can be mapped to the ICHA financing agents categories. On the other hand, the NHA use-of-funds categories consist of a mixture of ICHA health functions and ICHA health providers categories. It should be noted that the PNG NHA are not based on the Organization for Economic Cooperation and Development (OECD) System of Health Accounts (SHA) framework. The main reasons for this is that the first round of NHA work (development and estimation) was done before the SHA guideline (and the NHA Producer’s Guide) became available, and there had been no further NHA developmental work since the first round.
Table 2. Illustrative national health accounts table of Papua New Guinea, 1988-1990

<table>
<thead>
<tr>
<th>Uses</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
</tr>
<tr>
<td></td>
<td>National</td>
</tr>
</tbody>
</table>

1. General Administration
- Management, supervision and administration of health service programmes
- Health status and management information systems
- Construction of new offices, office renovation and maintenance, plant and equipment and staff housing
- Technical assistance and capacity building for policy and planning, management, health information systems, and financial and legal systems

Programme 2: Urban health facilities
- Public hospitals and their outreach and specialist services
- Staff salaries
- Construction and renovation of public hospitals, maintenance, plant and equipment and staff housing
- Referral and repatriation of patients to higher level facilities
Programme 3: Rural health facilities
- Rural hospitals, health centres and aid posts
- All staff salaries
- In-patient related activities such as food, laundry and security
- New constructions, renovations and maintenance, plant and equipment and staff housing
- Referral and repatriation of patients to higher level facilities

Programme 4: Family health services
- Routine administration
- Women’s health and safe motherhood
- Family planning and sexual health
- Nutrition
- School health programmes

Programme 5: Disease control
- Infectious diseases such as malaria, tuberculosis, sexually transmitted infections, diarrhoeal diseases, typhoid, leprosy, and acute respiratory infections
- Non-infectious diseases such as cancer, diabetes and cardiovascular diseases
- Other curative health activities
- Public health laboratories, including Central Public Health Laboratory
- Disease outbreak management

Programme 6: Environmental health and water supply
- Water supply and sanitation
- Waste management, vector control and housing
- Quarantine and food sanitation
- Environmental health impact assessment and management

Programme 7: Health promotion and education
- Production and distribution of materials, radio and TV broadcasting, drama and public awareness, forums and expositions
- Community health education programmes
- Mass production unit

Programme 8: Medical supplies and equipment
- Procurement and distribution of medicines, other medical supplies and equipment
- Area Medical Stores operational costs

Programme 9: Human resource development
- Curriculum review and development
- Pre-service health training and specialty training abroad
- In-service health training
- Training support to rural health services provided by hospitals
Programme 10: Support services

- Health radio network (presently costed under Programme 3 and sometimes Programme 1)
- Grants to other organizations such as the Red Cross Society, St. Johns Ambulance, National Board of the Disabled and Sir Buri Kidu Heart Institute and National Heart Foundation

There are plans to adopt the OECD SHA framework in future NHA work. But what would be needed to move forward are extensive training of the NHA Team on the new SHA framework (both theoretical and practical training), and external technical and financial support as already noted previously.

INFORMATION DISSEMINATION

NHA have been made available to the public through presentations in seminars or conferences. One venue is the National Health Conference (NHC) which is a public forum held annually. Stakeholders in the health sector meet at this forum to deliberate on key health issues. These stakeholders include provincial administrators, managers of public hospitals, members of public hospital boards, provincial health advisors, church health agencies’ representatives, other central government agencies’ representatives, Department of Health senior staff and donor partner representatives.

The existing arrangements are not satisfactory in terms of reach. Ideally, NHA information needs to reach the private sector as well. There is a need to explore other modes of disseminating the NHA, possibly through broadcast and alternative print media such as the television and newspaper.

At the moment PNG cannot report NHA estimates using the OECD SHA format. However, partial NHA estimates are provided to the WHO on an annual basis using the WHO data collection template. The WHO publishes the data provided by the Government in the annual World Health Statistics.

POLICY USES

The NHA and the health sector MTEF are used together as instruments to influence health policy in Papua New Guinea. For example, the NHA was the basis for the decisions to review the health services user fees policy, and to consider (and assess) the feasibility of introducing a compulsory health insurance for the formal sector employees of Papua New Guinea. The NHA data was used by the Department of Labour and Industrial Relations and the Department of Health to develop a joint policy paper on the piloting of the proposed compulsory national health insurance scheme for formal sector employees in PNG. These are examples of policy or reform areas that the Government is seriously considering as a result of information from NHA.
CONCLUSION

Some key lessons that can be drawn from the NHA experience about what are needed to sustain NHA work in the long-term include the following:

- Ownership of the NHA and commitment by government (in the form of budget allocation and manpower) are important.
- Political support is also critical.
- Effective networking of the Department of Health (the lead agency for NHA) with key central government agencies and the private sector is needed to ensure and maintain the flow of data required for NHA estimation.
- The initial NHA Team consisting of persons who were full time public servants (thus limited time available for NHA work) was adequate during the project phase while external support (funding and technical) was available; but not sufficient to sustain NHA work in the long-term.
- An adequate number of manpower who have NHA knowledge and skills need to be committed by the Government to sustain NHA work. NHA work in PNG needs at least three skilled personnel.
INTRODUCTION

Background information

The volcanic islands which make up the Independent Pacific Island State of Samoa are located 15 and 10 degrees south of the equator. The two large islands of Upolu and Savaii account for approximately 96% of the country’s total land area of 2,934 square kilometers. The 2006 population census for Samoa recorded a population of 180,714 persons, 48% of which are female. Life expectancy estimates for the country in 2006 were 71 for males and 72 for females.\(^1\)

New Zealand occupied the German protectorate of Western Samoa in 1914 at the outbreak of World War I. It continued to govern the islands until 1962, when the islands became the first Polynesian nation to reestablish independence in the 20th century. The country dropped the "Western" from its name in 1997. Samoa is now a Parliamentary democracy with a unicameral Legislative Assembly consisting of 49 members.

In 1996 the Government introduced a Statement of Economic Strategy (SES) for Samoa for the period 1996-1997. In this SES the Government recognized the importance of the private sector as being the engine of economic growth. At this same time the Government undertook a concerted institutional strengthening programme to strengthen government systems to further enable and foster the development of the private sector. The first SES for the period 1996-1997, as a follow on from past country development plans, was an effort by the Government for “taking the private sector into partnership to lead the country into a period of sustainable economic growth”.\(^2\) The sixth national strategy, the Strategy for the Development of Samoa, noted that “in 2006, the private sector accounted for about 58% of GDP and two thirds of formal employment,” \(^3\) reconfirming the vital role of the private sector in economic development.

The first SES was published at a time (1996-1997) when the Government was going through a process of introducing output/performance budgeting to link government expenditure to sector developments. This was an effort to strengthen transparency and accountability of public expenditure through the introduction of output/performance based budgeting to replace line item budgeting.

\(^1\) Samoa Bureau of Statistics Population Census Report, 2006  
The Economy

Samoa has a small and developing economy primarily dependent on agriculture, fisheries and tourism. Family remittances from abroad and development aid are also seen as being important to economic growth. The Ministry of Finance in its economic review for the second half of 2009 has noted that real GDP for Samoa totaled $257.37 million, showing a decline by 4.6% over the comparable 2008 period; The level of employment dropped by 9.3% (2,035) in June 2009 compared to the corresponding 2008 quarter; and export earnings in the second quarter of 2009 declined by 6.9% over the comparable 2008 period. These drops in national economic indicators were seen by the Ministry of Finance as being linked to the effects of the recent economic crisis.

The United Nations reviewed Samoa’s least developed country status in March 2006, and in December 2007 recommended graduation to developing country status in 2010. On the 18th June 2010 the United Nations General Assembly in recognition of the hardships faced by Samoa during the September 2009 tsunami agreed to extend by a period of three years, Samoa’s current status until 1 January 2014, before graduation from least developed country status takes place.

Samoa health care system

The Samoa Development Strategy 2008-2012 states that “the health status of the population is relatively good, but non-communicable diseases have increased since the late 1970s, with cardiovascular diseases now the number one cause of death. Rates of hypertension, diabetes, and obesity are all comparatively high” (SDS 2008-2012).

The Samoa Health Sector Plan for the period 2008-2018 has prioritized health promotion and primordial prevention as a major strategy to address the issue of noncommunicable diseases (NCD) over the plan period. The Plan notes the following as being priority areas to address over the time frame of the plan: "rapidly increasing levels of non communicable diseases, which will have major impacts on the health system, community mortality and morbidity and the economy of Samoa; importance of reproductive and maternal and child health for the long term health of the community; emerging and re-emerging infectious diseases; and injury as a significant cause of death and disability”.

Samoa’s formal publicly funded health system is made up of one national referral hospital situated on the island of Upolu, with around 200 inpatient beds and providing a mix of specialist referral and general acute care services and a secondary referral hospital on the island of Savaii. There are six district hospitals, three each on Upolu and Savaii. These district hospitals are “ranging in size from 10 to 24 beds and providing a mix of inpatient and outpatient care to defined health districts.” There are also seven health centres, six on Upolu and 1 on Savaii which serve to provide selected primary health care and maternal and child health care services.

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4 Government of Samoa, Ministry of Finance Quarterly Economic Review No. 45
5 United Nations General Assembly 64th Session Resolution
6 Ibid pp 16
7 Ministry of Health Samoa, Health Sector Plan 2008-2018, pp11
8 Ministry of Health, Clinical Services Plan for TTM Hospital, 2001, pp5
9 Ministry of Health Clinical services Plan, March 2001
Samoa has a rapidly growing private sector made up of a 21 bed private hospital, MedCEN Hospital, a Kidney Foundation providing dialysis treatment and approximately 15 private general practice clinics, three private pharmacies, two private dental practices as well as one nurse providing private nursing care.

**Healthcare financing system**

Health care remains predominately subsidized by the Government through publicly owned hospitals and funded through government public revenue, with the main source of income being taxes, fees and licenses. Overseas treatment under a scheme subsided by the Government is available for patients who cannot be treated in Samoa and treatment is sought in either Australia or New Zealand. There is also a scheme for overseas treatment funded by New Zealand in its bilateral aid programme with Samoa.


**Total health expenditures by source of funding:**

**Samoa, 1998/99 to 2006/07**

![Graph showing total health expenditures by source of funding](Image)

*Source: Ministry of Health, Samoa National Health Expenditures 2006/2007*

Although Government remains the main source of funds for health care services in Samoa, the Ministry of Finance in the Samoa Development Strategy 2008-2012 notes that “the financing of health services has been reviewed and an assessment made of the viability of a health insurance scheme, with a proposal from the National Provident Fund approved but on hold given other commitments.” Information from NHA as well as from other the Ministry of Health were used extensively to inform this review.

**History of national health accounts development**

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 main objectives of the

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10 Ministry of Finance, Samoa Development Strategy 2008-2012, Samoa
health sector reform was to “redefine the role of government and health sector stakeholders in the financing, provision and regulation of the health sector.”

The health sector reform programme was formally initiated in early 2000 with the receipt of financial and technical assistance from AusAID, through a five-year Samoa health project, as well as from the five year World Bank IDA credit funded Samoa health sector management project. Traditional development partners such as WHO also contributed through ongoing technical and bi-annual assistance programme.

Health policy and strategic sector planning was a function of the then Health Resource Planning Information and Research Division (HRPIRD) of the Ministry of Health, and the name of this division was later changed to the Strategic Planning and Policy Division (SDPD). The NHA concept was introduced as a part of the health sector management project. Funds were secured under this project in 2001 to obtain the services of a Health Economist, under a two and a half year technical assistant contract to assist in establishing and strengthening policy tools in the Ministry of Health. The production and establishment of NHA was a major part of the consultant’s terms of reference. After the initial two and a half year full time consultancy the consultant visited on short term basis twice to assist with the finalization of the two next sets of NHA developed by the Ministry of Health staff, with the latest set developed completely without outside technical assistance.

The first NHA that was developed was based on information for the financial year 31 July 1998-1 June 1999. This in fact became a pioneering set of national NHA for the Pacific island region. As this was a first set of NHA for Samoa, much time was taken to map out the information requirements taking into consideration all features of the health system in Samoa including those features unique to Samoa like the traditional healers and traditional birth attendants who practice traditional medicine in Samoa’s informal health sector.

One of the biggest contributions of this first NHA exercise to the Samoa health sector was the fact that for the first time financial information other than expenditure from the Government budget was available for public information.

The Director General of Health in the foreword to this first NHA formally recognized that “Up until now, information on health resource sources, expenditure and the distribution of expenditure in Samoa nationally has been limited to the public health sector. Health expenditure information previously reported thus reflected mainly only government expenditure on health. This Samoa 1998-1999 NHA report includes as much as it was possible, health resource information from all main sources and distribution of utilization for Samoa nationally inclusive of the formal private health sector, NGOs and traditional health sector as noted in the Methodology and Source of Information Section.”

One of the constraints recognized early on in developing this first NHA was difficulty in isolating expenditure information on health activities/functions that were implemented by and incorporated in the budgets of other government ministries. However, since the Government budget is now based on output/performance budgeting, a product of government reform programme with the objective to make the expenditure of public funds more transparent, more detailed information is available in

12 Preface by Director General of Health, National Health Accounts for Samoa, 1998-1999, Ministry of Health
government expenditures (relating expenditure figures to actual activities) which to a certain degree have helped to minimize this problem.

The decision to follow government budget cycle was made to simplify the process of obtaining data on government budget finance for the health sector as the Government was and still is a major funder for health services in Samoa.

In order to make the best use of the consultant during his two and half year contract, the Ministry of Health decided to undertake the exercise every second financial year, beginning from 1998-1999; not only to provide an opportunity to train local staff on the processes of estimating and writing up NHA but also to institutionalize the NHA exercise by making it a normal activity presented in the work plans of the Ministry of Health. Another reason for this was that at the time it was noted that the health sector in Samoa was undergoing dynamic changes as the private sector was growing (establishment of a 21 bed private hospital and more private general practitioners were opening their own clinics as well as more NGOs were providing health related care).

The definition of health was also undergoing change as the definition had expanded from a traditional concept of the medical model to one including definitions of health promotion and primordial prevention in line with the Alma Ata and Primary Health Care Declaration 1978 and the Ottawa Charter 1986. These health concepts were revitalized in the Samoa health sector mainly through the efforts of the Director General of Health as reflected in the 2008-2012 Health Sector Plan for Samoa. More currently this definition has expanded to include the concept of the health system and the six pillars of health as defined by WHO.


**INSTITUTIONAL RESPONSIBILITY FOR DEVELOPING AND PRODUCING NATIONAL HEALTH ACCOUNTS**

The Ministry of Health, through SDPD, is responsible for producing NHA in Samoa. It is important for the purposes of this paper to note that this division is also responsible for national health policy and strategic planning so that the links between producing NHA and using NHA for health sector policy and planning are very close.

During the preparation of the first set of NHA, a steering committee which includes the Ministry of Finance was established to guide the development of this first set of NHA. This committee has now been institutionalized and is recognized as having the oversight to monitor the development of all NHA for Samoa. This Steering Committee was established during the development of the 1997-1998 NHA to link the Ministry of Finance into the process.

The NHA information as it evolved from the first NHA exercise was discussed through stakeholder consultations which included representatives of most of the sources of information across the health sector. This was in recognition of the many stakeholders in financing health care in Samoa and in the
belief that the exercise of producing NHA needed to be inclusive of other sector partners early in the process of developing NHA in Samoa. This train of thought remains and the Ministry of Health believes is a strength of the NHA not only to market the concept widely but also to ensure that there is an opportunity to include input from other sectors to make the set of NHA as reflective as possible of how the health sector is resourced. Information on any oversights was used to strengthen the system of NHA in the current and subsequent rounds. The members of the NHA Steering Committee are annexed. The members of the working group that assisted in information collection as noted in the first set of NHA are also annexed for information. The SDPD is currently reviewing the membership of the Steering Committee and the working group to make it more cross sectoral.

There is current discussion with the SDPD of the need to create more positions within the division either as a separate section/unit of the division or as a part of the policy unit to take on the responsibilities for producing NHA as the demand on the existing staff for producing NHA as well as the required development and monitoring of health policies is a major effort for existing staff. This is seen as a natural progression for capacity building as demand for health policies is increasing, however, the Ministry of Health is working towards this in line with what capacity the local budget can sustain.

Presently the the memberships of the NHA Streering Committee and NHA Team as articulated in the Samoa NHA 1998-1999 report are as follows.

NHA Steering Committee
- Deputy Financial Secretary: Finance and Planning, Ministry of Finance
- Assistant Chief Executive Officer, SDPD, Ministry of Health
- Assistant Chief Executive Officer, Corporate Services Division, Ministry of Health

NHA Team
- Principal Health Policy Analyst, Ministry of Health
- Senior Policy Analyst, Ministry of Health
- Policy Analyst, Ministry of Health
- Principal Accountant, Ministry of Health
- Accountant Ministry of Health
- Principal Policy Analyst, Ministry of Finance

THE DEMAND FOR NATIONAL HEALTH ACCOUNTS: NATIONAL HEALTH ACCOUNTS AS A TOOL FOR INFLUENCING POLICY

NHA were introduced as a policy instrument to assist health policy and planning at a critical time when the Government, through its reform programme, was reviewing ways to strengthen the effectiveness and efficiency of the health system in Samoa recognizing the many changes that had taken place over the last decade within the health system.

The health reform programme culminated in 2006 in the legal separation of the former Ministry of Health into two entities. The two entities existing now are:
1. A reformed Ministry of Health which is responsible for providing sector: stewardship, governance, sector policy and planning as well as for ensuring health service performance and quality assurance of service provision from all health care providers, population wide health protection services including surveillance and environmental health are also a core function of the reformed Ministry of Health.

2. The National Health Service which is an organization managed by a Management Board and is responsible for the provision of healthcare from all publicly funded hospitals, inclusive of the integrated community health care services which are nurse led. These include maternal and child health services provided by NHS staff outside of the formal hospital setting.

The environment for the introduction of NHA as a policy tool was therefore timely as the demand for national health policies and associated strategic sector planning tools/mechanisms is an expected core output from the reformed Ministry of Health. The Director General of Health has been a vital supporter and advocate to ensure that NHA are produced by the Ministry to inform policies and plans and this has been crucial to ensuring that NHA continue to be institutionalized and recognized. NHA to date have been formerly submitted to the Cabinet Development Committee and officially launched by the Minister of Health.

USES OF NHA IN SAMOA – POLICY LINK

There have been some very practical examples of how NHA have been instrumental in influencing policy in Samoa. NHA were introduced as a tool to improve information for health policy and planning not in isolation but in line with other policy tools. These other policy tools included:

1. Health services plans, which make available information on the different types and levels of health care services provided by the Government at different settings and levels.

2. A patient information system (PATIS) capturing all demand for health care services in all publicly funded health facilities had been established several years earlier under funds from the AusAID. Modules for the pharmacy and laboratory were also put in place giving more detailed information on the types of laboratory tests required for diagnosis as well as information on the type and cost of drugs required to manage and treat diseases. In recognition of the growing private sector the Ministry of Health is currently expanding this information system to include information from the private sector.

3. The community health information system which captures community based health care, including maternal child health services, provided outside of the formal hospital setting.

4. Work undertaken by the Ministry of Health to define and capture information on vulnerable groups and accessibility to health care services in Samoa and reflected in the Vulnerable Groups Framework produced by the Ministry of Health in 2005.

5. A survey financed through WHO funds to obtain information on lifestyle risk factors through a Step Wise approach (STEPS Survey).

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13 CDC committee made up of all Cabinet ministers, government CEOs, and senior management staff of government ministries and state-owned enterprises
6. More recently the Ministry of Health, through the SDPD, has developed with financial assistance from the Health SWAp Programme a comprehensive demographic health survey. This undertaking was carried out by the Ministry of Health in collaboration with the Samoa Bureau of Statistics and Macro International.

The Ministry of Health believes that NHA at their most useful facilitates other policy tools to provide more wholistic information to further assure a wide range of well informed, evidence based, health policies and plans.

Wide marketing of NHA in various forums such as the CDC and launching these documents at events with a wide list of invitees from the Government and the private as well as NGO sectors has made the uses of NHA applicable not only to the Ministry of Health and the Government but also to the growing health related private sector industry for organizations corporate planning processes. However, the biggest challenge for the recognition of this tool is to be able to prove its worth in informing health policies and plans for improved national health outcomes.

Four examples of where NHA information assisted health policy and planning in Samoa are described next.

First, the Health Sector Plan 2008-2018 notes that the NHA for Samoa have provided critical information on allocation of health funds by function. The Plan states that “although health promotion and prevention of disease has been a priority for the Government over the last decade, current NHA findings show that for the 2002-2003 financial year, most of the Ministry of Health budget went into curative, treatment and rehabilitation areas of health care with only six percent of finance going into health promotion and prevention of disease services”\textsuperscript{14}.

This caused a concern to the Ministry of Health as the Ministry had prioritized health promotion as being a key strategy in a population which was showing rapid increases in lifestyle diseases as captured and confirmed using data from the PATIS and the STEPs survey.

This concern was exacerbated further when the NHA showed not only a small percentage of funds in total health expenditure invested in health promotion as a percentage of total expenditure in health, but also that a large portion of the health promotion programmes were funded through development aid funds, thereby, making sustainability over the long term an issue. In line with the these findings the Director General of Health, Mrs Palanitina Tupuimatagi Toelupe, in 2006 initiated a physical activity and nutrition home gardening programme working through a memorandum of understanding signed between the Minister of Health and the Minister of Women Community and Social Development for both Ministries to work together with communities through community institutions such as women’s committees, village mayor councils, youth and church groups to promote physical activity and healthy lifestyles. This was a means of transferring efforts and information on healthy lifestyles as originating from inside communities rather than perpetuating the past strategy of the Ministry of Health being the organization promoting healthy lifestyles from the MOH into the population.

\textsuperscript{14} Ministry of Health, Samoa Health sector Plan 2008-2018, pp40
This also led more recently to the establishment of a Parliamentary Advocacy Group being formed as an initiative and under the guidance of the Director General of Health in early 2010 to officially form a group of Parliamentarians to act as mentors to advocate the promotion of healthy lifestyles in communities. In the long run these strategies are efforts to sustain health promotion and make healthy lifestyles an inherent characteristic of community lifestyle in the attempt to, curb and reverse in the longer term, costs in health care exacerbated by the growing incidences of NCDs and associated high costs of life long medication to control and manage illnesses (secondary prevention) such as diabetes and hypertension.

Second, NHA have also created interest in how health is funded in Samoa. In 2002 the Government, through the Samoa National Provident Fund, began looking at alternative ways to finance health care. The information contained within the NHA was used together with required information such as percentage of population earning wages and salaries and percentage practicing subsistence (cash earning reality of the population) for information on the best way to establish an alternative system for financing health care using the Singapore model. However, this scheme was and still is on hold.

Third, information from NHA were also used by the Ministry of Health to review the out of pocket spending on outpatient and inpatient care user fees for all patients in public hospitals. These user fees were increased based on analysis of the information available from NHA as well as fee-for-service information.

Fourth, prior to the development of the first NHA in Samoa there was little official recognition by the formal health sector of the informal health sector or the traditional health system which includes traditional birth attendants (TBA) as well as a variety of traditional health care services provided by traditional healers. An exception was the early recognition by the Nursing and Midwifery Division of the TBA, alongside efforts to increase safety of practice of TBA through trainings carried out by this division and to encourage TBA to refer cases to the hospital if complications occur. This division also keeps a register of TBA that they carry out trainings for.

This was very much a forward looking initiative by the Division of Nursing and Midwifery that recognized early that there is a high number of women who prefer to visit TBA and it is ultimately the women’s choice where they seek care. This fact was linked to measures to further assure the safety of mother and child during the birthing process.

The 1998-1999 NHA formally recognized the role of the traditional healers (TH) in Samoa’s health care system and has the following information on traditional healers: “The NHA estimates indicates that the traditional health sector is a significant health provider accounting for a large proportion of out-of-pocket expenditure by households (33%). This indicates considerable utilization of the traditional healers by the Samoan population and raises policy questions about quality of service provision and regulation of this sector. At the same time it provided a unique opportunity to improve resource mobilization by building an appropriate partnership with this sector to achieve public health goals.”

15 The finding that a large traditional healer system existed in parallel to the Western Medicine health system provided evidence that there needed to be more formal recognition of traditional healers, for the sake of accountability and safety of practice by traditional medicine practitioners. Linked to this were efforts by the Ministry of Health to include TH and TBA to be subject to a new law passed by Parliament in 2007, the Healthcare Professionals Registrations and

15 National Health accounts for Samoa 1998-1999, pg iv, Ministry of Health Samoa
Standards Act 2007. Efforts to strengthen strategies for the regulation of traditional healers as part of the health system is currently being undertaken by the Ministry of Health through the Health Service Performance, Quality Assurance Medical and Allied Health Division and the Health Service Performance Quality Assurance, Nursing and Midwifery Division.

KEY ELEMENTS OF NHA INSTITUTIONALIZATION IN SAMOA

Institutional structure

The Ministry of Health, through the SDPD, is the core division for producing NHA in Samoa. The capacity of the SDPD to undertake NHA was enabled through the creation of a principal policy analyst senior policy analyst and a position for a new graduate in the policy section of the division during the period of the health reform programme. These same sets of positions were also created in the Planning Section, the Health Information Section and the ICT Section of SDPD to build the Ministry of Health’s capacity in these areas.

Funding through the World Bank credit financed project in the form of Technical Assistance – a consultant for a period of two and a half years – to develop and establish a NHA system and to train local staff allowed the NHA effort in the Ministry of Health to be a reality.

There was a concerted effort by the Ministry of Health to use the opportunity of having a consultant in-country available for two and half years to produce several sets of NHA during the period. Stakeholder information and consultation sessions to inform stakeholders of the NHA and findings after each set of estimates became available was also a strategy used by the Ministry of Health to market NHA as a health policy and information tool. Local Ministry of Health staff in line positions were encouraged to present the findings during these sessions and expected to answer questions which ensured that the consultant actually had to involve the local staff and work with them so that the core knowledge about the NHA estimates produced was passed on from the consultant to the local NHA team.

The second round of NHA for Samoa and subsequent rounds maintained a multi-sectoral approach to ensure a collaborative effort by government ministries, private institutions as well as NGOs together with the Ministry of Health, and, through the SPED, concrete ownership of the NHA by the Government. This would not have been possible if the MOH had not recognized that health is Samoa is everybody’s business.

Challenges and responses to challenges

One of the biggest challenges over the last 10 years to sustaining NHA has been the loss of trained staff to more lucrative employment opportunities. However, the fact that there was staffing depth in the Policy Section of the Division as well as exposure of the division’s staff in trainings and consultations has helped to some extent to minimize the impact and vulnerability to attrition especially as the skills required for NHA development are very technical. However, all staff that were trained by the consultant have since left the Ministry of Health and challenges to sustain the process were very real and remain.
The policy and planning function of the MOH was, at the time when NHA was also being established, a fairly new one calling for professional skills that were not traditional in the Ministry of Health. However, the reform process and the demand for skills in the area of policy and planning as a function of the stewardship and governance role of the Ministry greatly assisted and continues to make the viability of these skills recognized.

The training of local staff on NHA methodologies and analysis was very important as reflected in the consultants’ terms of reference for capacity building. When the consultant’s term ended, all spreadsheets, formulae and other relevant documentation were submitted to the MOH and these have enabled the Ministry of Health to keep producing NHA. The last set of NHA was developed by local staff in the SDPD with no outside technical assistance which was a great achievement.

It was also an important part of the institutionalization process that workshop sessions were held with staff from other divisions of the Ministry of Health as well as key government ministries including the Ministry of Finance, the Samoa National Provident Fund, Ministry of Education and Sports, among others, to build awareness of NHA, to market NHA as a decision making tool and to ensure an understanding of the information available for use in policy and planning by both the public sector as well as growing private sector and NGO sectors.

One of the challenges now is to obtain on-going training for the key people responsible for developing NHA in the Ministry of Health to keep them up to date with NHA development and learn from experiences of other countries. To sustain the NHA it is vital for core staff to obtain more formal training on health accounting as the two staff that attended the six week intensive training on NHA in 2002 in Vermont have since left the Ministry. A thorough understanding of the NHA system and methodologies is necessary not only to ensure the production of quality of information in line with international requirements but also to assure that features unique to Samoa are captured.

Skills in using the NHA information along with other relevant information for policy and planning are also important if the information from this tool is to be effectively and efficiently translated into health policy and planning.

It is vital that the local NHA team does not work in isolation but has opportunities to discuss and gain experiences in the production and use of NHA. The Ministry of Health staff over the last 10 years have attended short term trainings on NHA run by WHO, the World Bank and ADB, however, these are very short term (up to two weeks) and only useful if there already exists prior in-depth technical knowledge of the NHA framework and system in the Ministry of Health. This in-depth technical skill is vital if the framework of NHA is to be periodically reviewed to ensure it is in line with any changes in how the health system is financed in Samoa. There is also a need for continuous exposure of staff in the SDPD (especially in both the policy and planning sections of the division) to learn through experiences of other countries on ways to translate the information from NHA and articulate these into policies, plans and strategies to improve the Samoan health system and contribute to improved health outcomes.

Building capacity of the SDPD (strategic health sector policy and planning) needs to be very much a part of the efforts to institutionalize NHA in the Ministry of Health as NHA on their own are meaningless without the ability and capacity to interpret and analyze for health policy and planning purposes. The Ministry of Health was able through WHO assistance to send the Senior Policy Analyst (now the Principal Policy Analyst) for post graduate training in health economics. She only
has two more courses to complete to obtain her masters degree. Two other staff completed post
graduate programmes in the area of health services and have now achieved Assistant CEO position
in the SDPD and Corporate Services Division of the Ministry of Health. Development of NHA must
therefore cover professional skills development for health policy and planning.

One of the biggest challenges to the institutionalization of NHA is to prove the value of this tool in
the health sector and to healthcare professionals and link its application to improved health
outcomes.

Consistency of methodology

The methodology used in the production of NHA in Samoa follows the SHA classification and
methodology used by the OECD. The NHA reports health expenditures in three matrices with the
following classifications: sources of health funds, financing agents and intermediaries handling funds
and the end users of health funds. This has enabled an international comparison of the Samoa NHA
results with the rest of the world. The second round of NHA utilized the National Health Accounts
Producer Guide developed by the United States Agency for International Development (USAID),
World Bank, and WHO, which was launched and distributed in San Francisco in June 2003.

During the NHA exercises, a systematic effort was undertaken to collect information from the public
sector, private sectors and traditional sectors. Preliminary data reports on Ministry of Health
expenditure were generated by the Health Resource Planning Information and Research Division
(now the SDPD) of the Ministry of Health. Secondary data sources were identified and analyzed;
data gaps identified; and survey and data collection instruments were developed.

The Samoa NHA Report for 1998/1999 identifies the following key NHA activities/studies and
information sources:

1. Detailed study of the Department of Health Corporate Services files and accounts
2. Study of funding and utilization of health funds for the senior citizens scheme (NPF)
3. Detailed study of funding for drugs and drug utilization rates in Samoa
4. Study of funding sources and expenditure of the MedCEN Hospital
5. Study of funding sources and expenditure for traditional healers
6. Study of health funding sources and expenditure for private sector and government
ministries
7. A national household health expenditure survey was also undertaken with support of the
Statistics Department to get better information on out-of-pocket expenditure and coverage. 16

One of the unique features of the Samoan NHA is the capturing of information on TH (inclusive of
TBA) and recognising their role in health care services provision as captured in the first set of NHA
and reflected in all other subsequent NHA developed for Samoa.

In Samoa, Traditional Healers commonly use herbs, massage and prayers and occasional spiritual
invocations. Generally, Traditional Healers do not keep proper records of their practice; this has
contributed to the difficulty in determining how much people spend on this service. During the
development of the 1998-99 NHA, a survey on TH was carried out by the NHA Team. They

16 Ibid pg 23
depended mostly on the traditional healer’s memory for information required to complete the study. Another challenge lay in determining the cost of service for traditional healers as in most cases no monetary value is put on this service. Rather a type of barter system is used for payment of traditional healers services. In efforts to value these a price index was used to estimate the monetary value of those in-kind items given to the traditional healers in recognition and appreciation of patients when they were successfully treated\textsuperscript{17}. This method has since been used in all NHAs.

In order to firmly bed down the link between NHAs and health policy, and to prove the usefulness of this tool in health policy the 1998-1999 NHA for Samoa highlighted key health policy issues identified in information captured by NHAs. This was/is seen as being very important to marketing NHAs in Samoa as this provided/proved a direct link between NHA findings and health policy issues. This practice has continued in all subsequent NHAs. The policy issues highlighted in the 1998-1999 NHA are:

- Sustainability
- Resource allocation to different uses
- Cost containment
- Equity
- Transparency and accountability
- Resource mobilization
- Potential for the private sector\textsuperscript{18}

Currently NHAs are funded through the government budget to the Ministry of Health. WHO biennium budget has also been used to top up costs for stakeholder consultations and needed surveys, to capture, for example, information from Traditional Healers. WHO as well as SWAp funds have also been used to assist with publication costs. Published copies are formally launched by the Ministry of Health. Furthermore, the Ministry of Health through SDPD is currently designing a web page to put all publications on the Ministry’s website to allow for a larger consumption market.

Each set of NHA that has been published for Samoa has included a section on the challenges faced in compiling each set of NHA. This was done by the Ministry of Health to highlight challenges experienced in developing each set of accounts. Persistent challenges that have been recognized in NHA developed so far have included:

1. *Availability of Data*: Information on public and private expenditures was unavailable and the NHA team had to resort to primary data collection for example: data on imports of pharmaceuticals were sourced from the Ministry of Customs and Revenue as all pharmaceuticals are imported.

2. *Quality, Validity, and Reliability of Data*: Even when data was available its quality, validity, and reliability remained a matter of concern. Discrepancies existed between expenditure data provided by the Ministry of Finance and government agencies which has in part meant that the Ministry has had to await the availability of audited accounts.

\textsuperscript{17}Ibid pg 24
\textsuperscript{18}Ministry of Health Samoa National Health Accounts 1998-1999
3. **Lack of Standard Definitions:** Different local agencies classify expenditures differently, and do not have the same definitions for functions and services. This resulted in significant difficulties in compiling the NHA report and led the NHA team to write their own set of Definitions. (*Note: Since the development of the 1998-1999 and 2000-2001 Accounts the Standards Definitions Hand Book for Samoa as noted above has greatly assisted in maintaining consistency in subsequent NHA estimates).*

4. **Traditional Healers and Birth Attendance Data:** Information from Traditional Healers and Traditional Birth Attendants still remains a challenge on how best to estimate the exact value for in-kind payments/donations. To date mini surveys have been carried out and the keeping of a register of TBA by the Health Service Performance Quality Assurance for Nurses and Midwives Division of the Ministry of Health has greatly assisted in this area. It is expected that more information on Traditional Healers will become available since the establishment of a similar Division in the Ministry of Medical and Allied Health.

5. **Government awareness and support for NHA:** The level of awareness and support for the NHA activity in the past has been a challenge, however, the 2002-2003 NHA noted that awareness and support of the NHA had risen amongst public and private stakeholders, due to government support and the decision to conduct a periodic NHA report for Samoa. The NHA Team members from the various government offices were fully committed and understood the value of NHA; and the full support of senior level officials was extended to the NHA activity.

**CONCLUSION**

Samoa has managed to carry out six rounds of NHAs dating from the fiscal year 1998-1999. This is seen as being an enormous undertaking and is reflective of the support of the Government and in particular the management of the Ministry of Health. What had been seen as challenges after each round were recorded as a part of the NHA report enabling attempts to be made to lessen the impact of these challenges in subsequent rounds.

Some of the perceived reasons for the success in establishing NHA in Samoa have been:

1. The support of government in efforts to establish effective tools for health policy and planning especially with the reformed role of the Ministry of Health and need for support for health policy and planning as a legally mandated core function

2. The need for transparency and accountability, which was core in the government public sector reform over the years, meant more transparent budget systems that has to some degree assisted in capturing financial support in government budgets allocated to health activities.

3. The ability to link NHAs to policy issues in every set of estimates produced to date, thus proving the usefulness of this tool in health policy and planning.

4. The approval and support of the Public Service Commission to strengthen the SDPD through the creation of new positions in this division.
Main challenges, learned from lessons the different rounds of NHA work in Samoa, that should be addressed in the future include the following:

1. Training of staff in this very technical area needs to be ongoing and this requires donor support. Training and professional skills development is needed for ensuring thorough and in depth understanding of staff on the technical aspects of NHAs. Also needed are training/information sessions to share how information from NHAs can be translated into health policies and plans as well as for monitoring and reviewing these policies and plans.

2. There is a need to review the sectoral composition of the NHA Steering Committee and the NHA Team and the Ministry of Health, through the Assistant CEO SDPD, is pursuing this.

3. There was an expressed concern that the Ministry of Health needs to put in place a team within the SDPD Division of the Ministry of Health dedicated to producing NHA to further institutionalise the process. A concern was raised that having the policy section responsible for producing NHA estimates on top of their other work load (such as developing and monitoring health policies) can seriously affect the quality of the estimates. This may be a future challenge to sustaining the production of NHAs for Samoa.
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Mrs Palanitina Tupuimatagi Toelupe, the Director General/CEO Ministry of Health, Samoa,

Mrs Sarah Faletese – Sua , Assistant CEO, Strategic Development and Planning Division (SDPD), Ministry of Health, Samoa

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BIBLIOGRAPHY


Government of Samoa, Urban Health Services Plan, Ministry of Health, June 2003

Government of Samoa, TTM Hospital Services Plan, Ministry of Health, 2001


United Nations, United Nations General Assembly Resolution 64, 2010

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NATIONAL HEALTH ACCOUNTS
IMPLEMENTATION IN TONGA

(Tu’akoi ‘Ahio)

INTRODUCTION

Background information

Tonga is witnessing demographic and epidemiological transitions, putting the country’s health system under serious stress to address the double burden of disease and to adapt the supply of service and manpower to emerging health needs. Despite limited financial resources, providing universal access to health services remains a policy direction being pursued by the Ministry of Health.

The Government is the major provider of health services through a network of four hospitals, 14 health centres and 34 health clinics. Private sector health service providers consist largely of NGOs, and government medical officers and dentists who also work as private practitioners after office hours in the country’s capital, Nuku’alofa. The hospital bed occupancy rates are low, but increasing particularly in the central referral hospital, Vaiola Hospital: 50% in 2001/2002; and 58% in 2005/2006. The occupancy rates varied between 23% to 31% in 2001/2002, and between 19% to 33% in 2005/2006 in district hospitals in the outer islands.

The coordinates and manages the health sector with significant support from development partners, namely the AusAID, the World Bank, WHO, and others. At the same time, the Ministry of Health is also implementing health sector reform programmes including the health care finance component. The latter component seeks to address the following issues:

- How much does Tonga spend on health services?
- How should health services be funded?
- Who should fund health services?
- How should health resources be allocated?
- What should be the role of the donors, public and private sectors in Health?
- What health services should be delivered?

The Ministry of Health in collaboration with the World Bank implemented the health sector support project (HSSP), which included the health care finance component (HCFC). Under this project, the Ministry of Health conducted the national household expenditure survey (NHES) and initiated the establishment of the Tonga national health account in 2005. These two activities complemented each other and the pilot covered roughly the same time (period) 2001/2002.

A number of rounds of NHA have been produced and these include: 2001/02 in July 2004, for 2003/04 in July 2006, and for 2005/06 in March 2008. The NHA Unit of Health in the Ministry of Health is expected to produce the 2007/08 NHA sometime in 2010. The regular production of NHA
reports since 2004 has increased the recognition and acceptance of NHA in Tonga as an important policy tool.

**History of NHA work**

The Ministry of Health, through the HSSP, contracted an international consulting firm, the Australian Health International (AHI), to assist in the design and implementation of the HCFC activities including the establishment of NHA. NHA is a health expenditures accounting system introduced to the Government to guide the compilation of health financing data. NHA activities involved collecting public health expenditures data and other information from both public and private sectors. After the compilation of data on out-of-pocket (OOP) health spending (taken from the household survey mentioned previously), additional special surveys were conducted to cover data gaps including:

- Private health provider survey
- NGO survey
- External donor survey
- Traditional healers survey
- Private employer and private insurance surveys

In the first two NHA reports the Ministry of Health relied very heavily on technical as well as logistical support provided by the consultant hired through the HCFC/HSSP. In the third round of NHA work, about 75% of the work was done by the local NHA Team members who had been trained by the consultant in the previous two NHA rounds. The fourth and current round of NHA work is now 100% being carried out by the local NHA Team. The composition of the local team is as follows:

- Representative from the Ministry of Finance
- Representative from the Statistics Department
- The Senior Health Informatics Officer, Health Planning and Information, Ministry of Health
- The Accounting Officer Diplomate of the Account and Finance Section, Ministry of Health
- The Financial Analyst, NHA Unit (as a full time NHA staff)
- The Principal Health Administrator, Head of Administration Division and also the implementation officer of the HCFC

The NHA team played a central role in the successful institutionalization of NHA in Tonga. Additionally, the establishment of a NHA Unit in Ministry of Health in 2005 had strengthened the regular production of NHA.

Highlights from the Tonga NHA for selected years are described. The funding of the health sector and service delivery is predominantly public – the Government with 45% of total health expenditure (THE) in 2001/2002 and 52% in 2005/2006. The donor support was approximately 34% in 2005/2006 compared with 32% in 2001/2002. The total national health expenditure (NHE) in Tonga amounted to TOP $32 millions for the fiscal year 2005/2006, with per capita spending at TOP $317. Health spending as a share of GDP was 6.1% in 2001/2002 and increasing to 6.8% in 2005/2006.

The patterns of distribution of funds by sources and uses were generally similar in the prior years to that in the year 2005/2006. In 2005/2006 the Ministry of Health and donors are the main agents
More than 54% of total health expenditures (THE) was managed and spent directly by the Ministry of Health and 36% by donor agencies and NGOs. About 10% was spent by the private sector including households.

In terms of health providers, health services are provided mainly through the public sector. The private sector is small and consists mainly of government doctors who practice as general practitioners after office hours and a network of traditional healers mainly in the rural areas. The private pharmacy market is also small and local needs are served mainly by the public hospital pharmacy.

Health expenditures classified by function indicate that almost 24.0% is spent on capital formation of health care providers, 15.7% on inpatient curative services, 9.7% on pharmaceuticals, 8.8% on general government administration of health, 8.3% on research and development, 7.1% on inpatient curative (overseas treatment), 6% on education and training of health personnel, 2% on traditional healer services and 20.3% on collective preventative health (2005/2006).

Tables 1 and 2 summarize the sources of health funds and financing agents in Tonga.

**Table 1. Sources of health funds, Tonga 2005/2006**

<table>
<thead>
<tr>
<th>Sources of health funds</th>
<th>Amount (TOP)</th>
<th>Percent</th>
<th>Per capita (TOP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Finance</td>
<td>17,128,841</td>
<td>52.9</td>
<td>167.9</td>
</tr>
<tr>
<td>Private employer funds</td>
<td>21,182</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Private household funds</td>
<td>3,463,634</td>
<td>10.1</td>
<td>34.0</td>
</tr>
<tr>
<td>NGOs funds</td>
<td>494,832</td>
<td>1.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Other private funds</td>
<td>162,565</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Donor funds</td>
<td>11,090,676</td>
<td>34.3</td>
<td>108.7</td>
</tr>
<tr>
<td>Total</td>
<td>32,361,709</td>
<td>100.0</td>
<td>317.3</td>
</tr>
</tbody>
</table>

**Table 2. Financing agents, Tonga 2005/2006**

<table>
<thead>
<tr>
<th>Financing agents</th>
<th>Amount (TOP)</th>
<th>Percent</th>
<th>Per capita (TOP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>17,466,389</td>
<td>54.0</td>
<td>171.3</td>
</tr>
<tr>
<td>Private insurance enterprises</td>
<td>670,072</td>
<td>2.1</td>
<td>6.6</td>
</tr>
<tr>
<td>Private household out-of-pocket</td>
<td>2,639,761</td>
<td>8.2</td>
<td>25.9</td>
</tr>
<tr>
<td>NGOs</td>
<td>930,263</td>
<td>2.9</td>
<td>9.1</td>
</tr>
<tr>
<td>Donor agencies</td>
<td>10,655,345</td>
<td>32.9</td>
<td>105.5</td>
</tr>
<tr>
<td>Total</td>
<td>32,361,709</td>
<td>100.0</td>
<td>317.3</td>
</tr>
</tbody>
</table>

**INSTITUTIONAL STRUCTURE**

NHA work in Tonga was initiated as part of a World Bank project whose main objective was the refurbishment and redevelopment of Vaiola Hospital located in the mainland of Tongatapu. This project however included a health care financing component under which the NHA activities were implemented.

In 2005, three staff from the Ministry of Health, one staff from the Ministry of Finance and National Planning, and one staff from the Statistics Department were temporarily assigned to undertake NHA work in addition to their routine tasks and responsibilities. This group constituted the original NHA
The NHA team was assisted by a consultant, Mr Osmat Azzam, who was recruited for the project.

The consultant and the NHA team developed a health expenditure classification manual for Tonga. The classification schemes adopted followed the SHA but customized to suit the context of Tonga. They also developed survey questionnaires in conjunction with the Statistics Department and collected data from various health sector stakeholders including the following: NGO, donor agencies, private sector employers, private health providers, private health insurance, and traditional healers. Rider questions based on NHA requirements were also submitted to the Statistics Department for inclusion in the national household income expenditure survey (HIES). All these data collection efforts enabled the production of the first round NHA estimates for years 2001-2002 and these became available in July 2004. The same NHA Team produced the second round of NHA estimates for the years 2003-2004 and these were ready in July 2006. The third round of NHA estimates for the years 2005-2006 was completed in March 2008. The fourth round of NHA estimates for the years 2007-2008 will be ready sometime this year, 2010.

During the course of the World Bank project, in-house training workshops for the NHA Team were conducted by the consultant. The building of local capacity and the institutionalization of NHA were among the expected outputs and requirements of the project. Moreover, a World Bank mission aide memoire specified that a NHA Unit be established under the Administration Division. The new unit was formed and established, but initially without any permanent staff. The Ministry of Health later realized the need for permanent staff in the NHA Unit and created a position for a financial analyst. This position was filled in March 2007 by a former health planning officer of the Ministry of Health.

Every NHA Report has been the result of joint effort and collaboration between the Ministry of Health, on one hand, and health sector stakeholders and other (non-health) agencies providing data, on the other hand. The Health Information Section of the Ministry of Health regularly provides the electronic form of the data reported in the Minister for Health’s annual report data from routine data systems of the Government, however, do not always meet the requirement of NHA and generally requires further processing and manipulation. There were a few areas where additional data collection was undertaken to fill gaps in the Ministry of Health’s data system and these mostly involved collection of data from private health providers and from traditional healers, specifically on out-of-pocket spending by households.

The Ministry of Finance and National Planning assists in NHA production by providing annual data on actual expenses of the Ministry of Health and the Government as a whole. The Statistics Department also assists by providing data from the HIES and from other data sources. As mentioned previously, NHA rider questions are included in the HIES.

NHA is regularly commissioned by the Ministry of Health. However there is presently no legal instrument that governs the regularity of NHA production.
CAPACITY AND RESOURCE

Since the inception of NHA in Tonga in 2005, the NHA team has remained relatively intact. Four of the original team members, three from the Ministry of Health and one from the Statistics Department, are still directly involved in producing NHA estimates to the present. In early 2007 one member of the NHA team (a former Senior Accountant for the Ministry of Health) passed away and this could have left a serious gap in the NHA production process. Fortunately, majority of the NHA responsibilities of the Senior Accountant had been passed on to the newly appointed Financial Analyst of the NHA Unit before the former died. As of 2010, the NHA team consists of government officers listed in Table 3 below.

Table 3. Tonga NHA team composition, experience and time involvement

<table>
<thead>
<tr>
<th>Person</th>
<th>Qualification (including NHA experience)</th>
<th>Time involvement in NHA work</th>
</tr>
</thead>
</table>
| Principal Health Administrator, Ministry of Health | • Six years NHA experience  
• Health administration (Policy formulation, report writing) | As required for NHA activities             |
| Financial Analyst, Ministry of Health       | • Three years NHA experience  
• Economics and management, financial analysis and report writing | Full time                                  |
| Senior Health Informatics Officer, Ministry of Health | • Six years NHA experience  
• Economics and biostatistics, data analysis | As required for NHA activities             |
| Senior Statistics Officer, Government Statistics Department | • Six years NHA experience  
• Statistics (data analysis, conducting surveys) | As required for NHA activities             |
| Two Accounting Officer Diplomates, Ministry of Health | • Six years NHA experience  
• Financial management, data collection, conducting surveys | As required for NHA activities             |

The Tonga NHA team’s skills and capacity to undertake NHA work had been gained mainly from in-house training sessions during the NHA development phase and, more importantly, from learning-by-doing especially in the earlier rounds of NHA estimation. The team had also attended several NHA workshops organized by the WHO, including those in Sydney in 2007 and Fiji in 2009 and 2010, where lessons were learned from the NHA experiences shared by Pacific countries participants.

The skills and knowledge of the NHA Team needs continuing upgrading so that they can confidently and effectively influence Ministry of Health management and other policy makers to integrate the use of NHA into the policy process. Middle to high level executives at the Ministry of Health are asking for more detailed and advanced NHA tables such as disease-specific health sub-accounts and even health expenditures forecasts. Thus, the NHA Team will need more training, including in the areas of health economics and econometrics, to be able to produce an increasingly wide range of information being requested by policy makers.

Funding for the conduct of NHA activities in Tonga is sourced from the Ministry of Health’s annual budget allocation. The demographic and health survey (DHS) is currently being conducted jointly by SPC, the Statistics Department and the Ministry of Health with funding from donor partners. It is
expected that many of the NHA data requirements will be met by this survey. The DHS traditionally focuses on collecting data on women and children, but there was some flexibility to introduce additional modules and a NHA module was included. In previous years, a NHA module is what is commonly requested to be incorporated by the Statistics Department into their routine surveys. The DHS will collect population health information that are not usually captured by the Ministry’s routine data collection and will allow various types of analyses such as the association between social economic status and expenditure on health, and utilization of government health services compared to other health providers, among others.

To sustain the regular production of NHA in Tonga, support from the national and the executive levels have to be maintained. There should also be a legal instrument that will require the Ministry of Health to generate the NHA on a regular basis. Support for continuous capacity building is needed since the NHA team never had formal training on NHA concepts and methodologies. As mentioned previously, the health accounts knowledge and skills of the Tonga NHA team were obtained from in-house training sessions, learning-by-doing and from various regional workshops attended. Donors and international organization, such as the WHO, the World Bank, AusAID and others, have essential roles to play in the continuous strengthening of local capacity and, thus, in sustaining the NHA system in Tonga.

CONSISTENCY OF METHODOLOGY

The Ministry of Health has a comprehensive health information system (HIS) that provides the majority of the clinical and administrative data to support the needs of NHA estimation. The HIS includes information on inpatient and outpatient visits to government health facilities, clinical and non-clinical support services, community health services and some financial data. Thus, routine data collection through the HIS has adequately supplied most of NHA data requirements.

For information that it is not captured by the routine data collection mechanisms of the government, these are generally collected through special surveys. Standard survey questionnaires had been formulated and utilized since the first round of NHA estimation. These were amended when required during the following rounds of NHA work. For instance, the Private Health Providers Survey was eventually shortened to one page following comments from some of the provider respondents who said they found the original survey questionnaire too long.

The NHA Team conducted NHA awareness workshops throughout the Kingdom targeted at potential respondents of the different special surveys. These workshops explained to the survey respondents what data was needed, how data will be used and why the data was important. Then the survey questionnaires were distributed and filled up after the workshop. This approach proved very effective as experienced, for example, when the NHA team collected data from traditional healers. Four hundred fifty (450) active traditional healers in the Kingdom of Tonga known to the Ministry and the community were invited to attend an awareness workshop during the first round of NHA work. The NHA team worked together with the traditional healers in filling relevant fields of the survey questionnaire on the spot after the workshop. Of the traditional healers invited, about 80% to 90% attended and all the required information for NHA estimation was obtained.
Other data needed for NHA estimation and analysis are provided by the NHA Team member from the Statistics Department. These other data include actual population census counts and projections, foreign exchange rates and economic growth indicators.

Apart from the surveys, most of the data are available in electronic form and, thus, easy to use for NHA estimation purposes. The health expenditures data collected are entered and organized in a database. Each expenditure item in the database is classified (coded) according to various classification schemes including by financing source, by financing agent, by health provider and by health care function. The classifications of expenditures in the Tonga NHA basically follow the OECD’s SHA framework, but with some categories customized according to what are applicable in the Tonga context. That is, a few code extensions were made in some of the classifications to cover some unique features of the health care system in Tonga. Appendix 1 presents the classification schemes and categories used in the Tonga NHA. The Tonga NHA framework and classifications are documented in a Classification Manual and the manual has been applied consistently in every round of NHA estimated for Tonga.

The NHA estimates and report once completed go through a review and endorsement process. The NHA Team submits the NHA report for review to the National Health Development Technical Sub-Committee (NHDCTSC), of which the Director of Health is the chairperson and members include all the seven Ministry of Health executives (heads of divisions), the Senior Accountant, and Principal of the Queen Salote School of Nursing (Appendix 2). Additional members can be co-opted when required. The NHDCTSC after reviewing the NHA report then endorses it to the National Health Development Committee (NHDC) which is chaired by the Hon. Minister for Health and members include all NHDCTSC members and the Secretary for Finance and National Planning from the Ministry of Finance and National Planning.

INFORMATION DISSEMINATION

The NHA findings from each round of estimation have been regularly presented by the Ministry of Health, through dissemination seminars. The NHA reports are available in printed form (hard copies) and these are circulated to all health stakeholders in Tonga. Recently, the uploading and posting of the NHA documents on http://www.health.gov.to is being explored. The NHA reports are public documents and figures can be quoted for local or international uses.

POLICY IMPACT

Basically, without NHA, there would no way to determine what the Government and Ministry of Health, the private sector (households and NGOs) and development partners are together spending for health. With NHA estimates a number of basic financing questions can be answered, such as how much is spent for health, for what services and who benefits from spending for health. The findings from the various rounds of Tonga NHA revealed a number of important policy issues and subsequently were used as basis for policy formulation.
These uses of NHA for policy included:

- Analysis for the finalization of the national health care financing policy.
- Exploring alternative options to increase Ministry of Health revenues.
- Improving the efficiency of hospital service provision.
- Reviewing resource allocation between curative and preventive health services.
- Realigning use of resources to combat the increasing cases of NCD.
- Improving coordination of donor support and others sources of health funds.

The NHA findings were instrumental in the identification of the health care finance options presented and submitted to the Cabinet. Included among the options was the revised health services fees schedule of 2009, which was subsequently approved and implemented effective 1 February 2009.

Noncommunicable diseases are becoming an increasing health challenge in Tonga and a major concern to the Ministry of Health. Thus, it was decided that the third NHA Report (2005/2006) should provide detail on the health spending related to NCD. The NCD sub-accounts estimates within the NHA provided an indication of the level of national effort being given to address NCD, especially on the preventative aspects – and, as the sub-accounts showed, prevention was very low and, moreover, relied predominantly on donor support. Another important finding from the NCD sub-account was the significant difference between what was budgeted and what was actually spent for the NCD programme. This finding resulted to pressure to come up with policies or measures that would ensure that the allocated budget to NCD translates to actual spending.

CONCLUSIONS AND RECOMMENDATIONS

The full value of NHA is realized only after completing a three-step process: obtaining the NHA results; analyzing and interpreting the results; and formulating and implementing policies that were identified based on NHA findings. In the local institutional arrangements for NHA work, the role of the NHA Team should be to compile NHA and conduct initial analysis of the results. The NHA Steering Committee should serve as liaison between the NHA Team and the Ministry Executives and the rest of Government. The Steering Committee’s big picture perspective is useful for interpreting NHA results and identifying policy directions.

The establishment of a NHA Unit, complemented by a fulltime officer, strengthened the integration of the NHA activities into the routine functions and operations of the MOH. This was fundamental to the successful institutionalization of NHA.

Data collection is a critical step in NHA production. There is a strong need for closer collaboration between the Ministry of Health and key stakeholders to ensure that all data required for NHA estimation are made available to the NHA team on a timely basis. Further developments or extensions to the NHA, such as the development the sub-account for NCD, has proven effective for enhancing the usefulness of NHA as a tool for policy.

To summarize, this study recommends the following for consideration to ensure the quality of NHA estimates and to sustain NHA work in the long term:
1) That a strong political commitment be established to support the institutionalization of NHA.

2) That a strong commitment to NHA be established concretely at MOH in terms of the allocation of human resources, office space and other facilities to NHA activities.

3) That, institutionally, the NHA Team include the Ministry of Finance and National Planning, and Statistics Department in addition to the Ministry of Health, and be guided by a NHA Steering Committee; with the latter to also provide a strong link between the Ministry of Health and other government agencies.

4) That regular capacity development be provided to the NHA team in the form of formal training, e.g. on health economics and econometrics, and participation in international workshops and conferences on NHA.

5) That complete, good quality data from relevant stakeholders be provided to the NHA team on a regular basis and that this should be made mandatory.

6) That adequate technical and financial support from the Government and development partners be sustained, to support not only the production of NHA but also the translation of NHA findings into specific strategies and actions that can be adopted by the Government and the Ministry of Health.

7) That NHA findings be disseminated to relevant shareholders and use of NHA information be promoted to have direct impact on policy formulation.
AUTHOR’S ACKNOWLEDGEMENTS

The NHA Team of Tonga wishes to extend herewith our most sincere gratitude to the Deputy Prime Minister and the Ministry of Health for their strong political support and for including the Health Care Finance Component in the Tonga Health Sector Project which was funded through a credited agreement with the World Bank.

Also we would like to express our sincere thanks to the World Bank and the Australian Health International for guidance and technical support during the development of NHA and for introducing NHA as a tool for public expenditure review and health care financing policy formulation. Sincere thanks also to the consultant, Mr Osmat Azzam, for the technical and capacity building support for the development and institutionalization of NHA in Tonga.

We would like to give our thanks to the World Health Organization, especially to Dr Dorjsuren Bayarsaikhan, Regional Advisor in Health Care Financing, Division of Health Sector Development, WHO Western Pacific Region Office, for the continued support and assistance without which much of the NHA capacity development could not be sustained.

To the Secretary of Finance and National Planning, Mr ‘Aisake Eke; and Mr ‘Ataata Finau of the Statistics Department, we are very grateful for their steady support and cooperation, for allowing their staff to be part of the NHA Team and for their active contribution in the NHA Steering Committee.

Lastly our sincere thanks go to Dr Litili ‘Ofanoa, the former Director of Health and lead of the NHA Steering Committee, for his great support, guidance and commitment to NHA activities, and to the NHA Team for all the hard work without which the Ministry of Health would not be able to sustain the institutionalization of the NHA in Tonga.
Appendix 1: Expenditure Classifications in Tonga National Health Accounts

A. Classification by type of financing sources: codes and descriptions

FS.1 Public funds
   FS.1.1 Central government funds
   FS.1.2 Other public funds
FS.2 Private funds
   FS.2.1 Employer funds
   FS.2.2 Household funds
   FS.2.3 Non-profit institutions serving individuals
   FS.2.4 Other private funds
FS.3 Rest of the world funds

B. Classification by financing agents: codes and descriptions

HF.1 General government
   HF.1.1 Ministry of Health
   HF.1.2 Social security funds
   HF.1.3 Ministry of Education
   HF.1.4 Ministry of Agriculture
   HF.1.5 Ministry of Defense
   HF.1.9 Ministry of Finance (as a financing agents managing donors funds)
HF.2 Private sector
   HF.2.2 Private insurance enterprises
   HF.2.3 Private household out-of-pocket expenditure
   HF.2.4 Non-profit institutions serving households (NGOs and similar entities)
   HF.2.5 Private firms (other than health insurance)
HF.3 Rest of the world (donors)

C Classification by health providers: codes and descriptions

HP.1 Hospitals
   HP.1.1 General government hospitals
HP.2 Nursing and residential care facilities (Alonga Center)
HP.3 Providers of ambulatory health care
   HP.3.1 Offices of physicians (clinics)
   HP.3.2 Offices of dentists (dental clinics)
   HP.3.3 Traditional healers (offices of other health practitioners)
   HP.3.4 Out-patient care centers
      HP.3.4.1 Family planning centers (Tonga Family Health)
      HP.3.4.2 Out-patient mental health and substance abuse centers
      HP.3.4.4 Dialysis care centers
      HP.3.4.9 All other out-patient community and other integrated care centers
HP.3.5 Medical and diagnostic laboratories
HP.3.9 Other providers of ambulatory health care
   HP.3.9.1 MCH clinics
   HP.3.9.2 Community health centers
HP.4 Retail sale and other providers of medical goods
HP.4.1 Dispensing chemists
HP.5 Provision and administration of public health programmes
HP.6 General health administration and insurance
HP.6.1 Government administration of health
HP.6.9 Other (private) administration of health
HP.7 Other providers (rest of the economy)
HP.7.1 Establishments as providers of occupational health care services
HP.7.2 Private households as providers of home care
P.7.9 All other industries as secondary producers of health care
HP.8 Institutions providing health related services
HP.8.1 Establishments providing HRS
HP.8.2 Establishments providing technical assistance and training
HP.9 Rest of the world (overseas treatment providers)
HP.10 Provider expenditures not specified by kind

D. Classification by health care function: codes and descriptions

HC.1 Services of curative care
HC.1.1 In-patient curative care
HC.1.3 Out-patient curative care
HC.1.3.1 Basic medical and diagnostic services
HC.1.3.2 Out-patient dental care
HC.1.3.3 All other specialized health care
HC.1.3.9 Traditional health care
HC.2 Services of rehabilitative care
HC.2.1 In-patient rehabilitative care
HC.2.3 Out-patient rehabilitative care
HC.3 Services of long-term nursing care
HC.3.1 In-patient long-term nursing care
HC.4 Ancillary services to health care
HC.4.1 Clinical laboratory
HC.4.2 Diagnostic imaging
HC.4.3 Patient transport and emergency rescue
HC.4.9 All other miscellaneous ancillary services
HC.5 Medical goods dispensed to outpatients
HC.5.1 Pharmaceuticals and other medical non-durables
HC.5.2 Therapeutic appliances and other medical durables
HC.6A Prevention and public health services (programme spending)
HC.6.1 Maternal and child health; family planning and counseling (reproductive health)
HC.6.2 School health services
HC.6.3 Prevention of communicable diseases
HC.6.4 Prevention of non-communicable diseases
HC.6.5 Occupational health care
HC.6.9 All other miscellaneous public health services
HC.6B Prevention and public health services (spending on consultants fees)
   HC.6.1 Maternal and child health; family planning and counseling (reproductive health)
   HC.6.2 School health services
   HC.6.3 Prevention of communicable diseases
   HC.6.4 Prevention of non-communicable diseases
   HC.6.5 Occupational health care
   HC.6.9 All other miscellaneous public health services
HC.7 Health administration and health insurance
   HC.7.1 General government administration of health
   HC.7.2 Health administration and health insurance: private
HC.R Health related functions
   HC.R.1 Capital formation of healthcare provider institutions
   HC.R.2 Education and training of health personnel
   HC.R.3 Research and development in health
   HC.R.4 Food, hygiene and drinking water control
   HC.R.5 Environmental health
   HC.R.9 Other health related functions
Appendix 2: Ministry of Health Organizational Structure

- Minister for Health
  - National Health Development Committee NHDC
    - Vava'u Health District (CMO in Charge)
    - Ha'apai Health District (CMO in Charge)
    - 'Eua Health District (CMO in Charge)
  - NHDC Technical Sub Committee
  - Divisional Committees
    - Medical
    - Public Health
    - Dental
    - Nursing
    - Administration
    - Health Planning & Information
      - Med. Supt Clinical Services
        - Inpatient
        - Out-patient
        - Pharmaceutical
      - Med. Supt Non Clinical Services
        - Day Surgery
        - Dietry
        - ENT
        - Ophthalmology
        - Laboratory
        - Physiotherapy
        - National Diabetic Centre
      - Chief Medical Officer
        - Reproductive Health
        - Cervical Cancer
      - Chief Dental Officer
        - Community Dental Health
        - Public Health
        - Reproductive Health
        - Nursing Education
        - Hospital Nursing
      - Chief Nursing Officer
        - Accounts
        - Transport
        - Human Resource
        - Administration
        - NHGA
      - Principal Health Administrator
        - Health Planning
        - Medical Records
        - Health Information
        - Project Planning
        - Research & Evaluation
        - IT