Islamic Republic of Afghanistan

Ministry of Public Health

AFGHANISTAN NATIONAL HEALTH ACCOUNTS WITH SUBACCOUNTS FOR REPRODUCTIVE HEALTH 2011–2012

October 2013

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CONTENTS

Acknowledgments ..... **vi**

Executive Summary ..... **vii**

Abbreviations ..... **x**

1. Background **1**
1.1. Health Status and Demographic Trends in Afghanistan 1
1.2. The NHA Concept and Application 1
1.3. History of NHA in Afghanistan 2
1.4. Policy Objectives of the Second Round of NHA in Afghanistan 3
1.5. Policy Objectives of the First Round of the Reproductive Health Subaccount in Afghanistan 3
1.6. Strategic Objectives of Health Sector 3
1.7. Organization of this Report 4

2. Methodology **5**
2.1. Overview of Approach 5
2.2. Data Collection 6
2.2.1. Development Partner Surveys *6*
2.2.2. NGO Surveys *6*
2.2.3. Ministry Surveys *6*
2.2.4. Household Survey *6*
2.2.5. Employers and Insurance Providers *7*
2.2.6. RH-Specific Data *7*
2.3. Limitations 8

3. General NHA Findings **10**
3.1. Significance of Findings 10
3.2. Summary Statistics of General NHA 10
3.3. International Comparison 12
3.4. Financing Sources: Who Pays for Health Care? 12
3.4.1. Household Expenditures on Health *13*
3.5. Financing Agents: Who Manages Health Funds? 14
3.6. Health Providers: Who Uses Health Funds to Deliver Care? 15
3.6.1. Which Providers Consume Household OOP Funds? *16*
3.6.2. How Do OOP Expenditures Differ at Public and Private Facilities? *18*
3.6.3. How Do OOP Expenditures Compare to the Market Share for Services at Public, Private or Facilities Abroad? *19*
3.6.4. Which Providers Consume MOPH Funds? *20*
3.7. Health Care Functions: What Services and/or Products are Purchased with Health Funds? 21
3.7.1. What Goods or Services are Purchased with Funding from the Central Government and International Donors? *23*

4. Reproductive Health Subaccount Findings **25**
4.1. Significance of RH Findings 25
4.2. Summary of RH Findings 25
4.3. Financing Sources: Who Pays for RH Care? 27

4.3.1. Household Expenditures on RH *28*
4.4. Financing Agents 28
4.5. Providers 29
4.6. Health Functions 30
5. Conclusions & Policy Implications 32
5.1. Conclusions 32
5.1.1. General NHA *32*
5.1.2. RH Subaccount *32*
5.2. Recommendations 33
6. Institutionalizing NHA 37
Annex A. Classification of Health Expenditures 38
Annex B. General NHA Matrices 41
Annex C. RH Subaccount Matrices 50
Annex D. Major Contributors to Afghanistan's Health Sector 55
References 59

TABLES

Table 3.1: Summary of General NHA Findings, 2008–2009 & 2011–2012 11
Table 3.2: Breakdown of Expenditures by Financing Source, 2011–2012 13
Table 3.3: Breakdown of Financing Agents, 2011–2012 14
Table 3.4: Breakdown of Health Providers, 2011–2012 16
Table 3.5: Breakdown of Providers Of OOP Funds: 2011–2012 17
Table 3.6: Breakdown of OOP Expenditures by Public and Private Facilities, 2011–2012 18
Table 3.7: Breakdown of Other OOP Expenditures, 2011–2012 19
Table 3.8: Breakdown Providers of MoPH Funds, 2011–2012 21
Table 3.9: Breakdown of Health Functions, 2011–2012 22
Table 3.10: Breakdown of Expenditures by Function (Excluding Household OOP), 2011–2012 24
Table 4.1: Summary of RH Statistics, 2011–2012 26
Table 4.2: Breakdown of THE_{RH} By Source, 2011–2012 27
Table 4.3: Breakdown of THE_{RH} by Financing Agent, 2011–2012 28
Table 4.4: Breakdown of THE_{RH} by Provider, 2011–2012 29
Table 4.5: Breakdown of THE_{RH} by Health Function, 2011–2012 30
Table B1. Afghanistan General NHA—Financing Source by Financing Agent (FSXHF), 2011–2012 41
Table B2. Afghanistan General NHA—Financing Agent by Provider (HFXHP), 2011–2012 42
Table B3. Afghanistan General NHA—Provider by Health Function (HPXHC), 2011–2012 44
Table C1. Afghanistan RH Subaccount—Financing Source by Financing Agent (FSXHF), 2011–2012 50
Table C2. Afghanistan RH Subaccount—Financing Agent by Provider (HFXHP), 2011–2012 51

Table C3. Afghanistan RH Subaccount—Provider by Health Function (HPXHC), 2011–2012 52
Table C4. Afghanistan RH Subaccount—Financing Agent by Health Function (HFXHC), 2011–2012 54
Table D1. Contributors to Afghanistan's Health Sector, 2008–2009 55

FIGURES

Figure 3.1: Health Expenditure as a Percentage of GDP: Regional Comparison, 2008–2009 & 2011–2012 12
Figure 3.2: Breakdown of Expenditures by Financing Source, 2011–2012 13
Figure 3.3: Breakdown of Financing Agents, 2011–2012 15
Figure 3.4: Breakdown of Health Providers, 2011–2012 16
Figure 3.5: Breakdown of Providers of OOP Funds: 2011–2012 17
Figure 3.7: Breakdown of OOP Expenditures and Market Share by Public, Private and Facilities Abroad, 2011–2012 20
Figure 3.8: Breakdown Providers of MoPH Funds, 2011–2012 21
Figure 3.9: Breakdown Providers of MoPH Funds, 2011–2012 23
Figure 4.1: RH as a Percentage of THE, 2011–2012 27
Figure 4.2: Breakdown of THE_{RH} by Source, 2011–2012 28
Figure 4.3: Breakdown of THE_{RH} by Financing Agent, 2011–2012 29
Figure 4.4: Breakdown of THE_{RH} by Provider, 2011–2012 30
Figure 4.5: Breakdown of THE_{RH} by Health Function, 2011–2012 31

ACKNOWLEDGMENTS

The development of Afghanistan's National Health Accounts (NHA) report for financial year 1390 (2011–2012) has only been possible through the intensive efforts from many individuals and institutions. The NHA estimates are based on data collected by the Ministry of Public Health's (MoPH) Health Economics and Financing Directorate (HEFD) and contributions from donors, nongovernmental organizations, and numerous other government ministries and agencies.

We would like to take this opportunity to thank Mir Najmuddin Hashimi, the NHA Team Lead, and Shuhrat Munir, NHA Team Member, from the MoPH HEFD for their laudable and tireless efforts in the data collection, data analysis, and preparation of the report. We also appreciate the overall support and feedback provided by Mohammad Saber Perdes, Head of Health Economics Unit. Special thanks are also extended to Ahmad Shah Salehi, Director of the HEFD, for overseeing the entire NHA process.

We would particularly like to thank Lara M.J. Lorenzetti and Christine Kim from the USAID-funded Health Policy Project in Afghanistan for assisting the team with the data analysis and preparation and finalization of this report.

Sincerely,

Suraya Dalil, MD, MPH
Minister of Public Health

October 2013

EXECUTIVE SUMMARY

INTRODUCTION

The past decade has served as a transformational period for the Government of the Islamic Republic of Afghanistan (GIRoA). With a focus on rebuilding and strengthening its public sector, GIRoA and development partners have invested considerable financial, human, and technical resources into the country's growing health system. Between fiscal years 2008–2009 and 2011–2012, total national health expenditure grew nearly 45 percent and reached USD 1,500,975,945. Although the laudable efforts of various stakeholders have resulted in constructive changes for the health sector, this geographically and culturally diverse nation continues to face myriad challenges in expanding access to high-quality health services for all. Households, women in particular, experience numerous physical and social barriers that limit their access to general and reproductive health services.

NATIONAL HEALTH ACCOUNTS IN AFGHANISTAN

The Ministry of Public Health (MoPH) is committed to improving the health of the people of Afghanistan, including women and children in underserved areas. While the MoPH's strategy for increasing access to high-quality services is multi-faceted, particular emphasis is being placed on sustainable health financing (GIRoA, 2012a). Understanding the key players and financial flows in the health system enables governments to more effectively manage and allocate health resources. Therefore, GIRoA, through the MoPH, has adopted the National Health Accounts (NHA) framework, an international, standardized resource tracking methodology used to summarize and analyze health expenditures in a country's health sector. NHA measure total health expenditure (THE) for a specific period of time and identify the sources, agents, providers, and functions for expenditures in both the public and private sectors (WHO, 2003). NHA generate a comprehensive picture of the flow of funding, which provides policymakers with a more nuanced understanding of where health funds are generated and managed, as well as how and by whom health funds are being used.

NHA are powerful policy analysis tools. Governments can utilize NHA findings to evaluate health spending over time and examine the impact of health policies and initiatives. However, the true value of NHA lies in its regular production. The institutionalization of NHA as a standard practice allows governments to access relevant and timely health expenditure data for decision-making purposes. In recognizing the potential policy impact of consistent NHA data, MoPH conducted its first NHA in 2011 with data from fiscal year 2008–2009. This report presents findings from the country's second round of NHA, which used data from 2011–2012. It describes results from the general account as well as the findings of a reproductive health (RH) subaccount, a simultaneous sub-analysis specifically undertaken to better understand spending on RH services.

A SNAPSHOT OF GENERAL HEALTH EXPENDITURE

THE in 2011–2012 was USD 1,500,975,945. This represents a significant 43.8 percent increase since the first round of NHA in 2008–2009. However, THE as a percentage of gross domestic product (GDP) decreased from 10 to 8 percent over the three-year period. Total amount of government expenditure on health rose 31.7 percent over the three-year period,

reaching USD 84,148,093 in 2011–2012. However, this represents only a 0.2 percent increase in total government expenditures on health as a percentage of total government expenditures (from 4.0% to 4.2%).

Private sources (mainly households) were the main financiers of the Afghan health system, contributing USD 1,099,542,464 in 2011–2012. This accounted for nearly three-quarters of all health spending (73.6%). By contrast, the central government financed 5.6 percent (USD 84,148,093) of health expenditures in 2011–2012. International donor funding accounted for the remaining 20.8 percent (USD 312,468,367) of THE. These direct out-of-pocket (OOP) payments made by households are extremely inequitable for the poorest households. The central government should consider increasing its role as health financier and enlist the private sector to take a more active role as well.

In 2011–2012, 73.3 percent (USD 1,099,542,464) of health funds were managed by households in the form of direct OOP payments made at the point of service delivery. International donors controlled USD 218,857,427 or 14.6 percent of THE. The central government—through the Ministry of Public Health, Ministry of Defense, Ministry of the Interior, Ministry of Higher Education, and Ministry of Education—controlled 11.8 percent (USD 177,759,003) of THE. Finally, non-profit institutions serving households were responsible for managing 0.3 percent of THE in 2011–2012.

In terms of providers of care, retail sale and other providers of medical goods delivered the largest portion of services, accounting for 26 percent (USD 387,677,232) of THE. Expenditures were not attributed to this provider in 2008–2009, likely due to insufficient detail in existing datasets at that time. Outpatient care centers and hospitals provided 25 and 24 percent of THE, respectively, in 2011–2012. The fact that retail providers of medical goods deliver the largest portion of services is indicative of the lack of medical supplies and pharmaceuticals available at formal health facilities across the country.

In 2011–2012, services of curative care, including inpatient and outpatient services, accounted for 37 percent of THE. This finding is reasonable given the rollout of MoPH's Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) that expand curative coverage to households. An estimated USD 322,110,499 was spent on inpatient care while USD 232,782,176 was spent on outpatient care. Medical goods dispensed to outpatients accounted for 26 percent (USD 387,689,137) of THE in 2011–2012. Ancillary services, such as medical and diagnostic imaging, accounted for almost one-quarter of expenditures (USD 356,130,855) in 2011–2012.

A SNAPSHOT OF RH EXPENDITURE

Analyzing funding flows with respect to RH services helps stakeholders and decisionmakers better deliver and manage the essential, life-sustaining services needed by women and their children. In 2011–2012, Afghanistan spent USD 246,744,339 on RH, which accounts for 16.4 percent of THE. This proportion of spending is on par with spending in other countries that have successfully completed RH subaccounts, such as Kenya and Tanzania. However, until Afghanistan completes a costing study of its strategy to improve RH outcomes, it is difficult to establish whether this benchmark is sufficient.

Individual households financed more than three-quarters of THE_{RH} (USD 193,650,212) in 2011–2012. International donors also contributed a significant portion at nearly one-fifth of THE_{RH} (USD 46,487,494). The central government financed less than 3 percent (USD 6,577,377), while non-profit organizations serving households played a minor role, funding 0.01 percent of THE_{RH}. The central government may need to consider increasing investments in RH. Although donors are providing significant support at present, these entities are not considered sustainable or reliable sources of funding given the current political economy.

Through the MoPH, the central government controlled 11.3 percent of THE_{RH} in 2011–2012, which was slightly greater than 10.2 percent of THE_{RH} managed by international donors (USD 27,923,925 and USD 25,140,947, respectively). Many donors channel funds through the MoPH, which works to equitably allocate resources for RH throughout the country. Nevertheless, individual household OOP payments accounted for the greatest portion of RH funds at 78.5 percent of THE_{RH} (USD 193,650,212).

Outpatient care centers were the largest provider of RH services, providing 32.8 percent of THE_{RH} in 2011–2012 (USD 81,041,266). This seems reasonable given the expansive reach of BPHS and EPHS, which provide both antenatal and postnatal services. Retail sale and other providers of medical goods were the second greatest provider of THE_{RH} at 29 percent (USD 71,604,260). Hospitals provided 19.9 percent of THE_{RH} (USD 49,019,370).

Curative services accounted for the greatest portion of THE_{RH}, with 19.1 percent (USD 47,242,711) for inpatient care such as labor and delivery and 22.8 percent (USD 56,289,700) for outpatient services such as antenatal appointments. Medical goods dispensed to outpatients were the second largest health function, accounting for 29 percent of THE_{RH}. This includes all prescribed medicine, including vitamins and oral contraceptives. However, family planning services are typically classified under prevention and public health services, which account for just 3 percent of THE_{RH}. A more detailed study on contraceptive use might be useful in helping to clarify this finding.

KEY RECOMMENDATIONS

- Continue investigating new revenue generation strategies for the health sector
- Implement a risk protection mechanism for households, including health insurance coupled with co-payments and equity funds in hospitals
- Promote rational medicine use and improve drug supply
- Improve understanding of investments in preventive care
- Implement the MoPH Private Sector Strategy and regulate the private market
- Invest in capital formation of the health sector and consider public-private partnerships for diagnostic services at tertiary hospitals
- Continue to advocate for the institutionalization of NHA

ABBREVIATIONS

AADA	Agency for Assistance and Development of Afghanistan
ACTD	Afghanistan Center for Training and Development
ADB	Asia Development Bank
AECID	Spanish Agency for International Development Cooperation
AHDS	Afghanistan Health and Development Services
AKDN	Aga Khan Development Network
AMI	Aide Médicale Internationale
ARCS	Afghan Red Crescent Society
AusAID	Australian Aid
BDN	Bakhtar Development Network
BPHS	Basic Package of Health Services
CAD	Canadian Dollar
CAF	Care of Afghan Families
CDC	Center for Disease Control
CHA	Coordination of Humanitarian Assistance
CIDA	Canadian International Development Agency
Cordaid	Catholic Organisation for Relief and Development Aid
CSO	Central Statistics Organization
CWS PA	Church World Service Pakistan/Afghanistan
DAC	Danish Afghanistan Committee
EPHS	Essential Package of Hospital Services
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
GAVI	The Global Alliance for Vaccines and Immunization
GCMU	Grants and Contracts Management Unit

GDP	Gross Domestic Product
GIRoA	Government of the Islamic Republic of Afghanistan
GIZ	German Society for International Cooperation
HH	Household
IAM	International Assistance Mission
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IPD	Inpatient Department
ISAF	International Security Assistance Force
JICA	Japan International Cooperation Agency
LSHTM	London School of Hygiene and Tropical Medicine
MoD	Ministry of Defense
MoE	Ministry of Education
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
MoI	Ministry of the Interior
MoPH	Ministry of Public Health
MRCA	Medical Refresher Courses for Afghans
MSI	Management Systems International
NAC	Norwegian Afghanistan Committee
NGO	Nongovernmental Organization
NHA	National Health Accounts
NORAD	Norwegian Agency for Development Cooperation
NRVA	National Risk and Vulnerability Assessment
NZAID	New Zealand Aid
OECD	Organisation for Economic Co-operation and Development

OOP	Out-of-Pocket Expenditure
OPD	Outpatient Department
SAF	Solidary for Afghan Families
SCA	Swedish Committee for Afghanistan
SDO	Sanayee Development Organization (SDO)
SIDA	Swedish International Development Agency
SWSS	Sustainable Water Supply and Sanitation
THE	Total Health Expenditure
TIKA	Turkish International Cooperation and Development Agency
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USD	US Dollar
WFP	World Food Programme
WHO	World Health Organization

1. BACKGROUND

1.1. HEALTH STATUS AND DEMOGRAPHIC TRENDS IN AFGHANISTAN

The Islamic Republic of Afghanistan is a landlocked country in Central Asia with a population of approximately 27 million, representing various ethnic groups, languages, and religions. The majority of Afghans live in rural areas (72.1%), while 22.2 percent of people live in urban areas, with Kabul being the most populated urban city. Nomadic tribes constitute the remaining 5.7 percent of the population (GIRoA, 2013). The composition of Afghan communities is ever-changing, as migrant repatriation continues and more families move from rural to urban areas for social or economic reasons. Afghanistan's population is much younger than that of its regional counterparts, with 46.1 percent under age 15 years old (GIRoA, 2013). Less than 3 percent of the population is age 65 and older, and the estimated life expectancy at birth is 63 years for males and 64 years for females (APHI/MoPH et al., 2011).

Afghanistan has faced numerous challenges in providing health services to its culturally and geographically diverse population. The mountainous terrain, particularly in the northern parts of the country, provides a physical barrier to care, while decades of conflict have placed great burdens on the country's public health system, infrastructure, and other sectors. Nevertheless, the government of Afghanistan has focused on rebuilding its public sector over the past 10 years and, as a result, has undergone significant transitions. Afghanistan's economy has been steadily improving, reaching a total gross domestic product (GDP) of USD 18.9 billion in 2011–2012 or approximately USD 702 per capita (GIRoA, 2013). This represents a 74.7 percent increase from 2010. Policymakers are optimistic that with economic growth come improvements in the national health system.

While Afghanistan has made considerable progress in a number of health indicators over the past decade, there is room for improvement, particularly in maternal, child, and reproductive health. Afghanistan has one of the highest infant mortality rates in the world at 76 deaths per 1,000 births in 2010. The maternal mortality ratio is also high at 327 maternal deaths per 100,000 live births (APHI/MoPH et al., 2013). The total fertility rate was 5.1 children born per woman, and only 25 percent of women were using some method of contraception (APHI/MoPH et al., 2013). The barriers to reproductive health care are numerous and include physical access, high cost, limited number of female health care providers, and limited role of females as decisionmakers in their own health care (GIRoA, 2012c).

1.2. THE NHA CONCEPT AND APPLICATION

The National Health Accounts (NHA) framework is an international, standardized resource tracking methodology used to summarize and analyze health expenditures in a country's health sector (WHO, 2003). The framework enables governments to measure THE for a specified period of time. By analyzing expenditures in both the private and public sectors, the NHA generate a comprehensive picture of the flow of funding into the health system from various sources. Individual expenditures are subsequently mapped from the financing source to the financing agent, health provider, and health function, thereby providing

policymakers with a greater understanding of where health funds are generated and managed, as well as how and by whom health funds are being used.

NHA's relevance to policy analysis, as well as strategic planning and evaluation, has grown considerably over the past decade. In 2003, the World Health Organization published the *Guide to Producing National Health Accounts with Special Applications for Low-Income and Middle-Income Countries*, a manual that standardizes the overall NHA methodology and classifications used by developing countries. Based on International Classifications for Health Accounts (ICHA) codes, NHA help foster cross-country comparability in terms of health system financing. Furthermore, the regular production of NHA generates time series data—the analysis of which allows governments to evaluate health spending over time and examine the impact of health policies and initiatives. Aligning this information with national strategic plans can influence key decision making with respect to health spending. NHA technical teams in more than 50 countries have conducted NHA estimations and are working to institutionalize the methodology as a standard practice of government.

Strategic planning of a health sector often necessitates that information be gathered in a particular disease or service area. An NHA subaccount is the multi-dimensional analysis of financing, provision, and consumption constructed for a disease-specific area or intervention (WHO, 2010). Subaccount applications can be conducted simultaneously with the general NHA, which helps frame disease-specific spending within the context of THE. For this second round of NHA, the Ministry of Public Health (MoPH) conducted a reproductive health (RH) subaccount to better understand national spending on RH.

1.3. HISTORY OF NHA IN AFGHANISTAN

In recognizing the potential policy impact of NHA, the MoPH implemented its first round of NHA in 2011. The key motivations were to generate an initial estimation of THE; inform policy development; begin to project expenditure trends and rising health needs; and evaluate donor and domestic financing relative to long-term sustainability of the health sector (GIRoA, 2011a). The Health Economics and Financing Directorate (HEFD) of the MoPH conducted the first round of NHA using expenditure data from fiscal year (FY) 2008–2009. The findings highlighted several areas of improvement to be addressed by national health policies. Among other impacts, the findings motivated the 2012 costing studies of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) and helped inform the Health Financing Policy 2012–2020, the MoPH five-year Strategic Plan 2011–2015, and the National Health and Nutrition Policy 2012–2020.

Following the successful production of the first NHA report in 2011, the NHA team organized dissemination events that presented the main findings and policy implications to key stakeholders. These dissemination events illustrated the importance of stakeholder participation in providing the necessary data and highlighted the necessity for incorporating NHA as part of the decision-making processes for Afghanistan's health care system. The NHA steering committee discussed and approved production of the second NHA report for the year 1390 (2011–2012). The HEFD NHA team, which now serves as the institutional home for NHA, initiated the second round of NHA in 2012 with technical support from USAID-funded Health Policy Project (HPP). This estimation seeks to address numerous policy objectives, as outlined in section 1.4.

1.4. POLICY OBJECTIVES OF THE SECOND ROUND OF NHA IN AFGHANISTAN

The second round of NHA was conducted to estimate THE in the health sector during 2011–2012. Furthermore, policymakers were keen to understand the changes in health spending that occurred between the first and second rounds of NHA. The specific objectives included the following:

- Monitor current health expenditure trends to project future health financing needs
- Determine the distribution of THE by financing sources, financing agents, providers, and health functions
- Motivate a change in the public health budgeting process at both the central and provincial levels that can better identify underfunded areas in the health sector
- Evaluate donor financing relative to domestic financing and its implications for the long-term sustainability of Afghanistan's health sector
- Continue working toward institutionalization of the NHA methodology as a standard government practice

1.5. POLICY OBJECTIVES OF THE FIRST ROUND OF THE REPRODUCTIVE HEALTH SUBACCOUNT IN AFGHANISTAN

The government is keen to improve the health services provided to women and children in Afghanistan, particularly in light of the poor health outcomes experienced by these groups. To improve maternal and newborn health indicators, including the infant mortality rate and maternal mortality ratio, policymakers require more substantial information on health spending specific to RH services. In fact, the MoPH cites "facilitating evidence-based decision making through coordination of relevant and useful research" as a key strategic objective of the National RH Strategy 2012–2016. Therefore, the ministry called for an RH subaccount application to address the following policy objectives:

- Determine THE for RH
- Identify financing sources for RH goods and services
- Determine the country's reliance on international donors for RH
- Understand the public sector's contribution to RH
- Evaluate the financial burden on households for RH care
- Identify managers of RH funds
- Identify providers of RH services
- Determine the types of goods and services being purchased with RH funds

1.6. STRATEGIC OBJECTIVES OF HEALTH SECTOR

The advancements made in the health system over the past several years can be attributed in part to the MoPH's dedication to its fundamental belief that access to health is a right that should be enjoyed by all Afghans. The MoPH's mission to "improve the health and nutritional status of the people of Afghanistan with a greater focus on women and children, disabled, marginalized populations, and underserved areas" is being carried out in a number of ways (GIRoA, 2011b).

At the cornerstone of the MoPH's vision is a commitment to (GIRoA, 2012b)

- Good governance and stewardship
- Efficient, equitable, and sustainable health financing mechanisms
- Promotion and production of health resources
- Expanding access to high-quality health services

1.7. ORGANIZATION OF THIS REPORT

The remaining four sections of this report cover

1. The NHA methodology and its purpose, aims, and applications in-country, and the methodology used by the NHA technical team to produce this second estimation
2. The findings of the general and RH subaccount, respectively
3. Conclusions, policy implications, and recommendations
4. Strategies for the institutionalization of NHA

The annexes include

A. Explanation of the NHA classification of health expenditures
B. General NHA matrix outputs from the NHA production tool: financing source by financing agent, financing agent by provider, provider by health function, and financing agent by health function.
C. RH subaccount matrix outputs from the NHA production tool
D. Breakdown of major contributors to Afghanistan's health sector

2. METHODOLOGY

2.1. OVERVIEW OF APPROACH

The 2011–2012 Afghanistan NHA was conducted in accordance with the *Guide to Producing National Health Accounts, with Special Application for Low-income and Middle-income Countries* (WHO, 2003) and utilized both primary and secondary data. The data collected were analyzed using the *NHA Production Tool User Guide: Version 1.0*.

To allow for cross-national comparisons, NHA classifications derived from the System of Health Accounts (SHA) of the Organization for Economic Cooperation and Development (OECD) were used. The International Classification for Health Accounts (ICHA) is a comprehensive system that classifies NHA into the following four dimensions:

1. **Financing Sources**—entities that provide health funds. These include the Ministry of Finance (MoF), households, and donors.
2. **Financing Agents**—entities that receive funds from financing sources and use them to pay for health services, products, and activities. This category accounts for those entities authorized to manage and organize funds. For example, though the MoF may allocate funds to the MoPH, it is the MoPH that decides how the funds will actually be distributed within the health system. Therefore, the MoPH is the financing agent.
3. **Providers**—entities responsible for delivering health services. Examples include private and public hospitals, clinics, and health care stations.
4. **Functions**—goods, services, or activities that providers deliver to beneficiaries. Examples include curative care, long-term nursing care, medical goods (e.g., pharmaceuticals), preventive services, and health care administration.

Based on the above categories, the following NHA standard tables were developed:

- Financing Sources (FS) by Financing Agents (HF)
- Financing Agents (HF) by Providers (HP)
- Providers (HP) by Functions (HC)
- Financing Agents (HF) by Functions (HC)

Data were collected from various government documents and key informants. Primary data were collected from the following sources:

- Donor surveys (bilateral donors, multilateral donors, and the International Security Assistance Forces [ISAF])
- Nongovernmental organization (NGO) surveys (those responsible for delivering health care services)
- Ministry surveys (fund recipients)
- National Risk and Vulnerability Assessment (NRVA) household survey

The following secondary data sources were used:

- Afghanistan National Budget 1390 (operating and development budgets)

2.2. DATA COLLECTION

2.2.1. DEVELOPMENT PARTNER SURVEYS

A list of all development partners (including bilateral and multilateral organizations and United Nations [UN] agencies) providing support to health sector activities was prepared, using the MoPH International Relations Department database and other sources. Twenty-six donors were sent questionnaires, accompanied by an official request from the MoPH soliciting the entity's participation and explaining how the information will be used. All donors provided expenditure data of their health programs for 2011–2012. Donors tend to play the role of financing sources and agents.

2.2.2. NGO SURVEYS

In Afghanistan, the primary and secondary health care services, BPHS and EPHS, respectively, are delivered under two contracting mechanisms: contracting-in, with the MoPH as the service provider, and contracting-out with NGOs.

Lists of all the BPHS and EPHS implementing NGOs were obtained from the Grants and Contracts Management Unit (GCMU) of the MoPH. These NGOs were invited to a workshop where they were trained on the NHA concept and the data collection format to be used for the second round of NHA. All NGOs[1] returned completed survey questionnaires. NGOs act in different capacities as identified by the NHA; they can be public providers, agents, and financing sources (minimal).

2.2.3. MINISTRY SURVEYS

In addition to the MoPH, several other ministries have health programs and receive funds from the national budget for the provision of health services. These ministries include the Ministry of Defense (MoD), Ministry of the Interior (MoI), Ministry of Education (MoE), Ministry of Higher Education (MoHE), and the National Department of Security (NDS). The MoD, MoI, and NDS operate hospitals and clinics nationwide, while the MoHE operates medical faculties and teaching hospitals in select provinces. The MoE operates health centers in some schools as well as health education programs—pharmaceuticals for their health centers as well as relevant staff salaries are included in this NHA. A survey was circulated to each ministry. All four ministries responded to the survey; the NDS did not provide any data. Line ministries, especially the MoPH, are often agents, as well as financing sources and providers of health services.

2.2.4. HOUSEHOLD SURVEY

According to health accounting methodology, out-of-pocket (OOP) spending by households is typically defined as direct spending on health goods or services after the deduction of third-party payments, such as insurance. However, it is often necessary to estimate the gross direct spending, not taking into account reimbursements by third-party sources.

[1] AADA, ACTD, AHDS, AKDN, AMI, BDN, BRAC, CAF, CHA, Cordaid, CWS PA, Health Net TPO, IbnSina, IMC, MOVE, SDO, Merlin, MRCA, SCA, SAF.

National health accounts commonly use one or more of four approaches to estimate household out-of-pocket spending for health:

1. Direct derivation of estimates from data reported in surveys of household expenditure
2. Indirect derivation of estimates from data reported in surveys of household expenditure, by reference to national accounts estimates of household consumption
3. Indirect derivation of estimates by triangulating and integrating different data sources, such as household surveys and surveys of economic enterprises
4. Use of estimates of household spending reported in the national accounts (which may be based on one of the above approaches).

In this round of NHA the household OOP expenditures were derived from the NRVA 2011–2012, a nationally representative multi-purpose survey completed by the Afghanistan Central Statistics Organization (CSO). The main objectives of the survey are to provide up-to-date information for assessing the situation of the people of Afghanistan and to furnish data needed for monitoring progress toward development goals. Several general questions on OOP expenditures on health care were added to the NRVA 2011–2012 for NHA purposes. For example, households were asked about the facilities where treatment was most recently sought; the costs associated with their visits (e.g., diagnostics, pharmaceuticals, and in-kind payments); the number of visits over the past year (inpatient) or past month (outpatient); and whether they stayed overnight.

2.2.5. EMPLOYERS AND INSURANCE PROVIDERS

NHA estimations typically involve employers as financing sources and insurance providers as financing agents. However, Afghanistan's public and private insurance sectors are underdeveloped. An operational social health insurance scheme does not exist despite small-scale programs during the 1960s and 1970s (GIRoA, 2012a). The role of private insurance providers and employers in the financing of health services is emerging but remains extremely limited. Therefore, these types of health spending are not included in this NHA.[2]

2.2.6. RH-SPECIFIC DATA

The RH subaccount was conducted concurrently with the general account and, as such, additional country-specific classifications were created to accurately map RH-specific expenditures to the relevant financing source, financing agent, provider, and health function. The infrastructure for regularly collected health information in Afghanistan is weak but improving. Most institutions provide low-quality expenditure data that is scarcely disaggregated by disease, condition, or service type. Nevertheless, the NHA team used secondary data for this analysis. To fill information gaps, the team conducted additional analyses on all data collected and triangulated figures from various sources. In cases where projects had non-targeted funding, an RH-specific allocation factor was created and applied. Utilization data and costing data from the Health Management Information System (HMIS) and HEFD were used to develop these ratios.

[2] As the private sector grows, particularly in the development of private health insurance, the NHA will aim to reflect these expenditures in the health system. Currently, as private health insurance is small, fragmented, and not formalized, data are not yet available.

To analyze the data for the subaccount, the NHA technical team used the following methods:

1. **BPHS allocation factor:** The allocation factor for the BPHS expenditure data is calculated based on utilization data for 2011–2012. Total utilization of RH-related services was divided by total utilization for all services in the same year. The percentage allocated for RH from the BPHS is 25 percent.

$$\frac{\text{Total weighted}^{3}\text{ utilization for RH services}}{\text{Total weighted utilization for all services}} = \%\text{ utilization for RH (allocation factor)}$$

2. **EPHS allocation factor:** The NHA team used the results of the EPHS hospital costing study conducted in 2012—all expenditure related to RH (gynecology, family planning, and obstetric services) are allocated to the RH subaccount. The allocation factor for EPHS services is 20 percent (17% for inpatient care and 3% for outpatient care).
3. **Ordinary budget allocation to RH from MoPH (central and provincial):** The number of staff working for RH and Nutrition were determined out of the total number of staff at the central MoPH and then divided by total number of staff working in the MoPH central level. The percentage allocated from the MoPH's administrative budget for RH is 1.5 percent. The same method was used to determine MoPH RH-specific expenditure at the provincial level, generating an allocation factor of 1 percent.
4. **Kabul National Hospitals:** Costs related to RH (gynecology, family planning, obstetric services) for Kabul National Hospitals were determined using a 2012 costing report conducted by HEFD (GIRoA, 2012d). Allocation factors for inpatient and outpatient care were determined to be 12 percent and 2 percent, respectively.
5. **EPI project:** Experts from the EPI department of MoPH met with HEFD and determined an allocation factor for the project based on the number of vaccines related to RH as well as administrative workload. A 12 percent allocation factor was used for this project.

2.3. LIMITATIONS

The NHA technical team employed the methodology as described in the WHO's *Guide to Producing National Health Accounts, with Special Application for Low-income and Middle-income Countries*, which ensures that Afghanistan's estimations of THE will be comparable at an international level. Furthermore, decision making for the 2011–2012 NHA was closely linked with the decisions made during the first estimation so as to improve comparability from year to year. Nevertheless, some limitations of this study should be mentioned.

Obtaining high-quality data in Afghanistan is often challenging, and although every NHA is an estimation of THE, technical teams require accurate data to determine an estimate closest to reality. Therefore, data quality and reliability are considered limitations in this study. Additionally, as NHA analysts build their technical expertise and become more comfortable with the methodology, they are able to make better decisions for how

[3] Weights for utilization data were derived from time allocations required for each RH service area, based on HMIS data.

expenditure data should be analyzed. With this in mind, and despite the NHA team working to make parallel decisions with the first estimation, differences in reported expenditures from year to year could be more representative of variations in NHA production rather than actual changes in health spending. For example, the 2011–2012 NHA used the NRVA for household data, and a partnership was formed to ensure that this same dataset be used on a continual basis. However, the Afghanistan Mortality Survey was used in the 2008–2009 estimation. Due to fundamental differences in the survey designs, data collection, and analysis plans, one must be careful when drawing comparisons from year to year. This is particularly relevant when comparing a country's first and second round of NHA. As the framework becomes institutionalized, this typically becomes less of an issue.

Another challenge for this round was the unavailability of household expenditure data. The CSO was conducting the NRVA analysis concurrently with the NHA estimation. Consequently, the initial timeline for releasing the NHA report was impacted by delays in the cleaning and analysis of NRVA data. A final limitation of this study was the lack of primary data used to estimate expenditures in the RH subaccount. Due to the lack of RH-specific data, the technical team used secondary datasets to estimate spending on RH. Given the country's experience with data quality and reliability, this will likely provide only a rough estimate of expenditures for RH in Afghanistan. Primary RH-specific data will be collected for future rounds of the NHA.

3. GENERAL NHA FINDINGS

3.1. SIGNIFICANCE OF FINDINGS

Afghanistan's first round of NHA provided an essential first look at spending and resource allocation within the country's health system. The findings have helped inform various policy and planning processes to date. However, while a single NHA in isolation provides a comprehensive overview of health spending in a given year, the true value of the NHA is in the ability to compare spending from year to year. With the findings from 2011–2012, policymakers have the ability to evaluate spending over time and compare it with goals and objectives of national strategic plans. As the NHA technical team hones their skills and data becomes more reliable and widely available, the regular production of NHA reports will provide time series data to help decisionmakers determine trends and better evaluate the successes and areas of improvement within the health sector.

3.2. SUMMARY STATISTICS OF GENERAL NHA

Table 3.1 below describes the overall findings of the general NHA account for 2011–2012. For reference, the table also provides findings from the 2008–2009 data. Over a three-year interval, GDP in Afghanistan increased by about 74.7 percent, according to the CSO (from USD 10,843,340,000 to USD 18,952,000,000). THE also grew dramatically, increasing 43.8 percent from USD 1,043,820,810 in 2008–2009 to USD 1,500,975,945 in 2011–2012. Consequently, THE as a percentage of GDP, decreased from 10 to 8 percent over the three year period. Total government health expenditure rose 31.7 percent over the three year period; however, this represents only a 0.2 percent increase in total government health expenditures as a percentage of total government expenditures (from 4.0% to 4.2%). Private households remain the main financier of the Afghanistan health system, accounting for nearly three-quarters of all health spending in 2011–2012 (73.3%). Household OOP spending per capita rose USD 10 between 2008–2009 and 2011–2012. In terms of providers of health services, retail sale and other providers of medical goods provided the largest portion of THE at 26 percent. Finally, services of curative care, including inpatient and outpatient services, remain the largest health function and accounted for 37 percent of THE. Portions of the summary table will be discussed in greater detail in subsequent sections.

TABLE 3.1: SUMMARY OF GENERAL NHA FINDINGS, 2008–2009 & 2011–2012

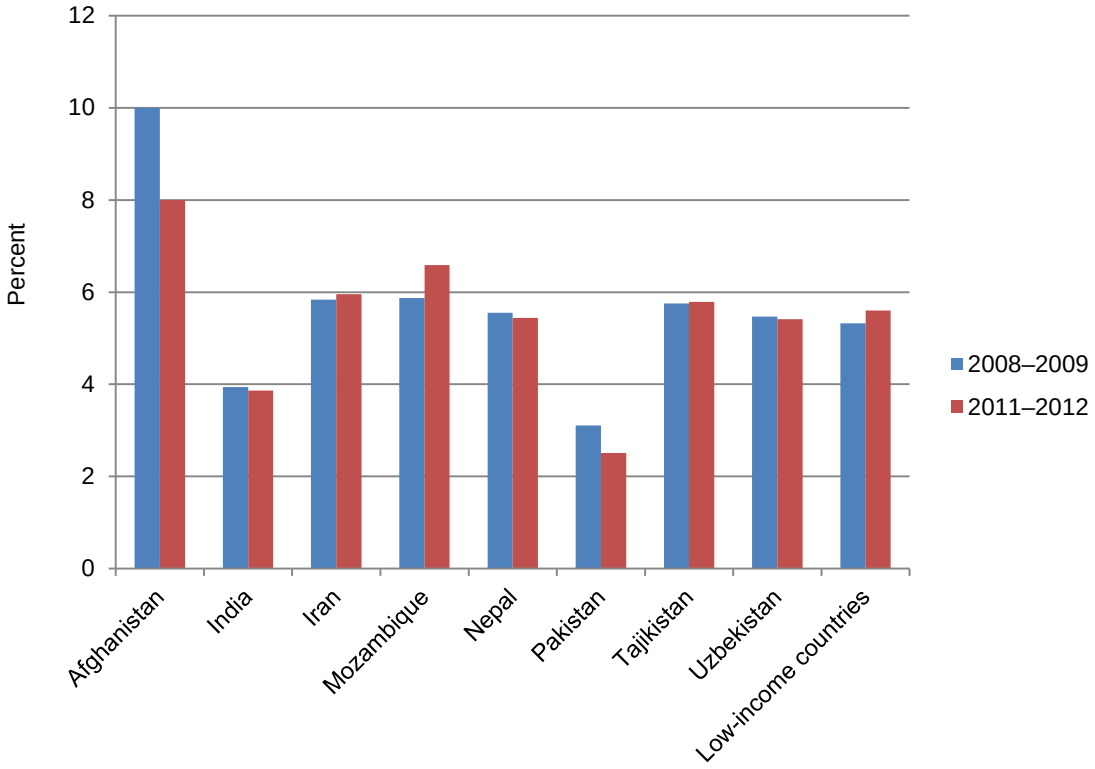
NHA Indicators	2008–2009	2011–2012
General		
Total population	25,011,400	27,000,000
Total real GDP (USD)	10,843,340,000	18,952,000,000
Average exchange rate (USD: Afs)	1:50	1:47
Total government health expenditure (USD)	63,892,239	84,148,093
Total health expenditure (THE)	1,043,820,810	1,500,975,945
THE per capita (USD)	41.73	55.59
THE as % of real GDP	10.0%	8.0%
Government health expenditure as % total government expenditure	4.0%	4.2%
Financing Source as a % of THE		
Central government	6.0%	5.6%
Private	76.0%	73.6%
Rest of the World	18.0%	20.8%
Household (HH) Spending		
Total HH (OOP) spending as % of THE	75.0%	73.3%
Total HH (OOP) spending per capita (USD)	31	41
Financing Agent Distribution as a % of THE		
Central government	11.0%	11.8%
Household	75.0%	73.3%
Non-governmental organizations	5.0%	0.3%
Rest of the World	8.0%	14.6%
Provider Distribution as a % of THE		
Hospitals	29.0%	24.0%
Outpatient care centers	32.0%	25.0%
Retail sale and other providers of medical goods	28.0%	26.0%
Other[4]	11.0%	25.0%
Function Distribution as a % of THE[5]		
Curative care	59.0%	37.0%
Pharmaceuticals	28.0%	26.0%
Prevention and public health programs	5.0%	5.0%
Health administration	5.0%	6.0%
Capital formation	2.0%	1.0%
Ancillary Services	-	24.0%
Other[6]	1.0%	1.0%

[4] Provision and administration of public health programs, general health administration, and all other industries are included in other/provider.
[5] Comparison of functions across years may not be possible due to the significant changes in classification, which allows for a more detailed breakdown.
[6] Other services include rehabilitative care and health functions not specified by kind.

3.3. INTERNATIONAL COMPARISON

Afghanistan dedicated 8 percent of its GDP to health expenditures in 2011–2012. This represents a 2 percent decrease since 2008–2009. However, over the three-year period, as shown in Figure 3.1, Afghanistan has contributed more of its GDP to health than its neighbors and income peers. This may be due to the high rates of OOP spending (73.3%) in Afghanistan compared with other countries in the region, which is on average 58 percent (WHO, 2013). On the other hand, the public sector is the main source of funding in developed countries, contributing, on average, 72 percent (OECD member country average) (OECD, 2013). The average percent of GDP spent on health in low-income countries was 5.6 in 2011–2012, increasing only slightly from 5.3 percent in 2008–2009.

FIGURE 3.1: HEALTH EXPENDITURE AS A PERCENTAGE OF GDP: REGIONAL COMPARISON, 2008–2009 & 2011–2012



Sources: World Bank Databank, 2013; Afghanistan figures from the country NHA 2008–09 & 2011–12.

3.4. FINANCING SOURCES: WHO PAYS FOR HEALTH CARE?

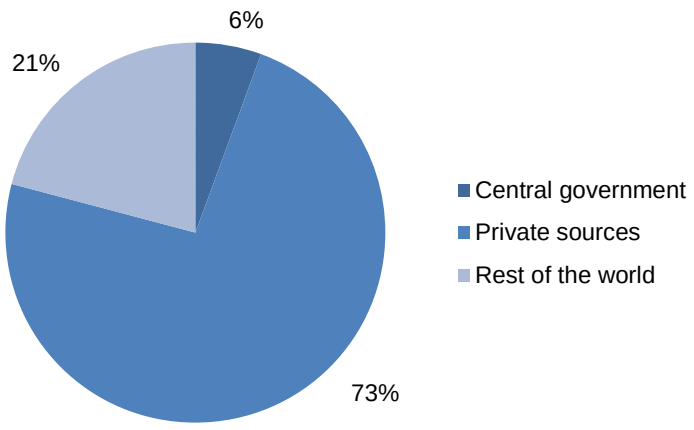
A financing source is an entity responsible for putting funds into the health care system. The NHA framework captures information on public (government), private, and donor sources operating within the health system. As shown in Figure 3.2, in 2011–2012, private sources served as the major financier of the health system, contributing nearly three-quarters of health funding. Individual households through direct OOP payments made to health providers financed 73.3 percent alone. This burden on households decreased only slightly

from 75 percent in 2008–2009. The central government financed 5.6 percent of health expenditures in 2011–2012, which remained constant over the three-year interval. International donor funding increased slightly since 2008–2009, accounting for 20.8 percent of THE in 2011–2012.

TABLE 3.2: BREAKDOWN OF EXPENDITURES BY FINANCING SOURCE, 2011–2012

Financing Source Distribution as a % of THE (USD)		
	Amount	2011–2012
Central government	84,148,093	5.6%
Private sources	1,104,359,485	73.6%
Households	1,099,542,464	73.3%
Non-profits serving households	4,817,021	0.3%
Rest of the world	312,468,367	20.8%
Total	**1,500,975,945**	**100%**

FIGURE 3.2: BREAKDOWN OF EXPENDITURES BY FINANCING SOURCE, 2011–2012



3.4.1. HOUSEHOLD EXPENDITURES ON HEALTH

Individual households financed 73.3 percent of health expenditures in 2011–2012. While this represents a slight decrease from 75 percent of THE in 2008–2009, total spending actually increased from USD 787,076,258 to USD 1,099,542,464. This represents a 39.7 percent increase in spending over the three-year period. Since the public and private insurance sectors are underdeveloped, all household expenditures are in the form of OOP payments made directly to providers at the point of service delivery. For the purposes of this exercise, household health expenditures include all direct inpatient and outpatient medical costs, as well as any ancillary expenditure associated with the care received such as medicine or transportation.

3.5. FINANCING AGENTS: WHO MANAGES HEALTH FUNDS?

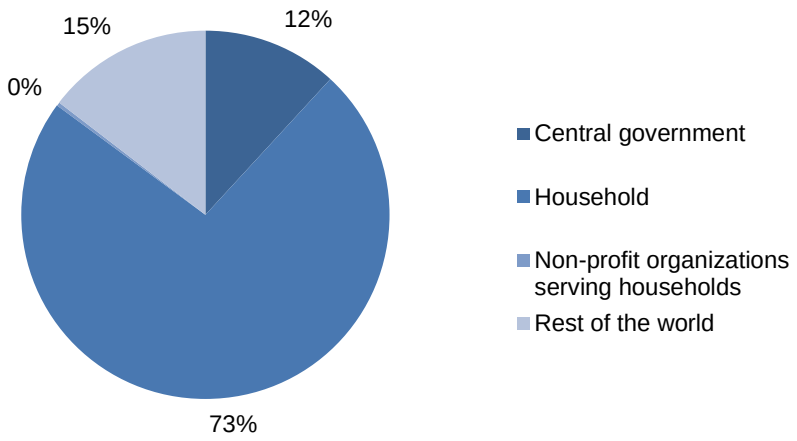
Financing agents are the entities responsible for managing health funds. They receive resources from financing sources and distribute them to health providers. Financing agents are not just intermediaries of the health system; instead, they are crucial components that maintain programmatic control over how resources are allocated and channeled to appropriate services. Financing agents in Afghanistan include various government ministries, private household OOP payments, non-profit institutions, and international donors.

Figures 3.3 shows that in 2011–2012, the majority of health funds were managed by households in the form of direct OOP payments made at the point of service delivery. Despite a small decrease from 75 percent in 2008–2009 to 73.3 percent in 2011–2012, the financial burden continues to fall heavily to households as managers of health funds. The role of international donors as financing agents increased over the three-year interval. In 2011–2012, donors controlled USD 218,857,427 or 14.6 percent of THE. The central government—through the MoPH, MoD, MoI, MoHE, and MoE—controlled the third largest share of health funds at 11.8 percent of THE (USD 177,759,003). This represented an increase of 1 percentage point from 2008–2009. Non-profit institutions serving households controlled 5 percent of THE in 2008–2009 but were responsible for just 0.3 percent of THE in 2011–2012.

TABLE 3.3: BREAKDOWN OF FINANCING AGENTS, 2011–2012

Financing Agent Distribution as a % of THE (USD)		
Central government	177,759,003	11.8%
Ministry of Public Health	162,127,582	10.8%
Ministry of Defense	8,489,362	0.6%
Ministry of the Interior	5,990,485	0.4%
Ministry of Higher Education	971,441	0.1%
Ministry of Education	180,133	0.0%
Household	1,099,542,464	73.3%
Non-profits serving households	4,817,021	0.3%
Rest of the world	218,857,457	14.6%
Total	**1,500,975,945**	**100%**

FIGURE 3.3: BREAKDOWN OF FINANCING AGENTS, 2011–2012



3.6. HEALTH PROVIDERS: WHO USES HEALTH FUNDS TO DELIVER CARE?

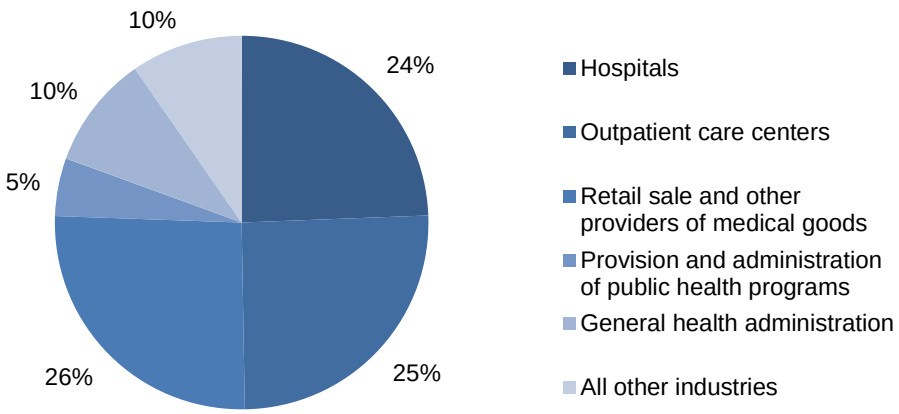
Providers of health care are defined as those entities or institutions that receive funding in exchange for producing a good or service meant to improve or maintain the health and well-being of an individual. There are many types of providers currently operating in Afghanistan that include both public and private hospitals, outpatient care centers, pharmacies and shops, public health programs, and general health administration.

In 2011–2012, as shown in Figure 3.4 below, retail sale and other providers of medical goods provided the largest portion of services, accounting for 25.8 percent of THE. Expenditures were not attributed to this provider in 2008–2009, likely due to insufficient detail in existing datasets at that time. Outpatient care centers and hospitals provided comparable levels of care in 2011–2012 with 25.3 and 24.4 percent of THE, respectively. This represents a 1.6 percent decrease since 2008–2009 for hospitals and an 8.7 percent decrease for outpatient care centers. The expenditures by general health administration increased in 2011–2012, rising to 9.8 percent from 6 percent in 2008–2009. General administration refers to administrative costs at the central and provincial levels and does not capture those of specific facilities. This large increase in general administration may be attributed to increased technical assistance for the MoPH.

TABLE 3.4: BREAKDOWN OF HEALTH PROVIDERS, 2011–2012

Provider Distribution as a % of THE (USD)		
Hospitals	366,083,995	24.4%
Outpatient care centers	380,247,062	25.3%
Retail sale and other providers of medical goods	387,677,232	25.8%
Provision and administration of public health programs	75,371,292	5.0%
General health administration	146,724,292	9.8%
All other industries	144,872,073	9.7%
Total	**1,500,975,945**	**100%**

FIGURE 3.4: BREAKDOWN OF HEALTH PROVIDERS, 2011–2012



3.6.1. WHICH PROVIDERS CONSUME HOUSEHOLD OOP FUNDS?

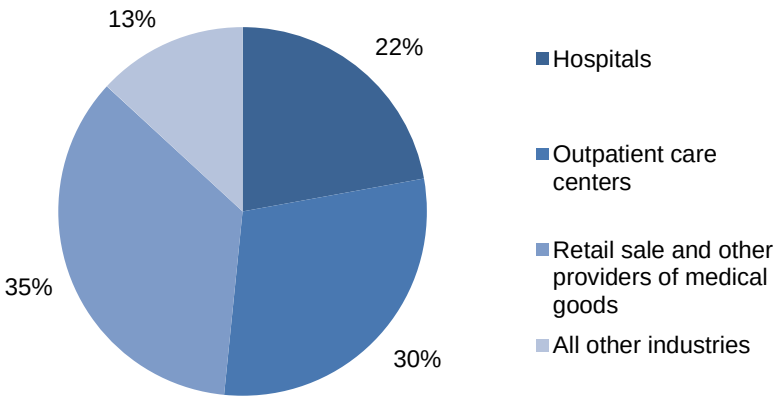
Because households finance three-quarters of the health system through OOP payments made at the point of service delivery, it is important for policymakers to understand the main providers interfacing with individual households. Figure 3.5 describes the distribution of OOP funds to providers in 2011–2012. Retail sale and other suppliers of medical goods provided the largest portion of OOP expenditures with 35.3 percent, which is comparable to the 2008–2009 estimate of 38 percent. Outpatient care services provided the second largest percentage of services, accounting for 29.5 percent of OOP expenditures for both outpatient care centers (10.2%) and medical and diagnostic laboratories (19.2%) combined. This fell slightly from 32 percent in 2008–2009. OOP spending at outpatient centers may seem high when considering the availability of BPHS services; however, anecdotal evidence suggests that individuals are often required to seek services at private centers, particularly if medical or diagnostic imaging is required. Hospitals provided a smaller share of services for OOP

expenditures in 2011–2012, falling from 30 percent to 22.1 percent over the three-year interval. Finally, the NRVA asked households for the amount spent on ancillary costs related to their health care, such as transportation. This sum is represented by all other industries as secondary producers of care, accounting for 13.1 percent of OOP expenditures.

TABLE 3.5: BREAKDOWN OF PROVIDERS OF OOP FUNDS: 2011–2012

Distribution of Providers for Household OOP (USD)		
Hospitals	243,505,175	22.1%
Outpatient care services	323,816,985	29.5%
Outpatient care centers	112,229,202	10.2%
Medical and diagnostic laboratories	211,587,782	19.2%
Retail sale and other providers of medical goods	387,677,232	35.3%
Vision products	4,946,536	1.3%
Hearing products	1,439,660	0.4%
Medicine	381,291,035	98.4%
All other industries as secondary producers of health care	144,543,073	13.1%
Total	**1,099,542,464**	**100%**

FIGURE 3.5: BREAKDOWN OF PROVIDERS OF OOP FUNDS: 2011–2012



3.6.2. HOW DO OOP EXPENDITURES DIFFER AT PUBLIC AND PRIVATE FACILITIES?

Households made more direct payments to private facilities than to public ones in 2011–2012. More specifically, as shown in Table 3.6, 61.8 percent of OOP payments were made to private facilities—of which 38.2 percent went to inpatient department (IPD) services and 23.5 percent went to outpatient department (OPD) services. Public facilities received 38.2 percent of household OOP payments—of which 27.6 percent went to IPD services and 10.6 percent went to OPD services. Overall, the majority of payments for both public and private facilities have gone to IPD services. Table 3.6 also shows the distribution of payments for pharmaceuticals—42.9 percent at public facilities and 57.1 percent of payments at private facilities. The high percentage of costs to pharmaceuticals at public facilities may be attributed to a lack of drugs at public facilities due to stockouts because of a limited medicine supply or due to over-prescription of medicines, thereby forcing patients to purchase out of pocket in the private sector.

TABLE 3.6: BREAKDOWN OF OOP EXPENDITURES BY PUBLIC AND PRIVATE FACILITIES, 2011–2012

Providers	Total OOP		Pharmaceuticals	
Public facilities[7]	420,337,883	38.2%	163,388,920	42.9%
IPD	303,557,587	27.6%	105,606,385	27.7%
OPD	116,780,295	10.6%	57,782,535	15.2%
Private facilities[8]	679,204,581	61.8%	217,902,115	57.1%
IPD	420,432,004	38.2%	110,016,332	28.9%
OPD	258,772,577	23.5%	107,885,783	28.3%
Total	**1,099,542,464**	**100.0%**	**381,291,035**	**100.0%**

Table 3.7 shows the breakdown of other OOP expenditures on food and transportation in 2011–2012. Two major expenditures households make direct payments for include transportation and food. Often food is not provided at facilities, particularly for patients staying overnight; families, therefore, take the responsibility to bear the cost for food. Transportation is frequently stated as a top barrier to accessing health services. Households spent USD 75 million on transportation costs alone. As ambulance services are not common in Afghanistan, most transportation payments are made directly by households.

Many households seek health care abroad, especially for inpatient services that are not available in Afghanistan. Table 3.7 also shows the breakdown of OOP expenditures for seeking health care abroad—26 percent of OOP payments, which makes up 19 percent of the THE.

[7] Public facilities: national hospitals, regional hospitals, provincial hospitals, district hospitals, comprehensive health centers, NGOs, mosques, nursing homes, and other public health facilities.
[8] Private facilities: private hospitals, private clinics, pharmacies, other private health facilities, and health facilities abroad (when not disaggregated).

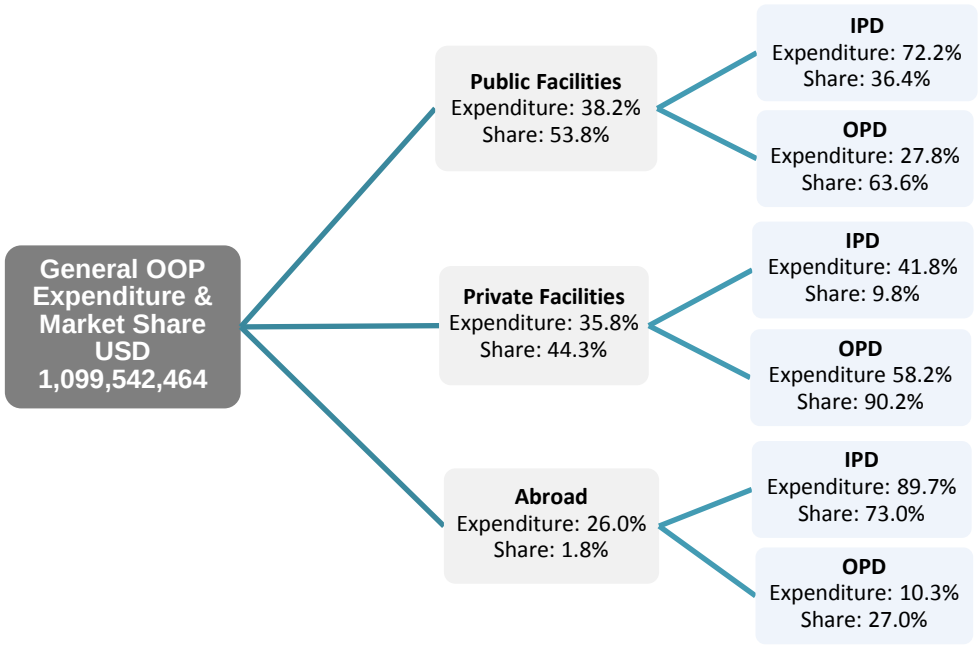
TABLE 3.7: BREAKDOWN OF OTHER OOP EXPENDITURES, 2011–2012

Breakdown of other OOP expenditures	
Transportation	75,579,594
Food	68,963,478
OOP spent for health seeking abroad	
IPD abroad	255,883,619
OPD abroad	29,506,370
Total OOP abroad	**285,389,989**
OOP payments abroad as percentage of total OOP	26%
OOP payments abroad as percentage of THE	19%

3.6.3. HOW DO OOP EXPENDITURES COMPARE TO THE MARKET SHARE FOR SERVICES AT PUBLIC, PRIVATE OR FACILITIES ABROAD?

When comparing household OOP payments across expenditures, it is clear that most direct payments are made for services obtained from private facilities (35.8%). Households make 38.2 percent of direct payments to public facilities and 26 percent to health services abroad. The market share distribution, which is measured by the number of visits or admission as a percentage to compare utilization of one facility type over another, differs from the distribution of expenditures. Figure 3.7 provides the breakdown of both expenditure and market share figures in 2011–2012. Although the highest percentage of expenditure was at private facilities, more than half of the households used public services. Moreover, only 1.8 percent of households obtained services abroad, though spending 26 percent of the total household OOP payments. Further disaggregating these figures shows the distribution across IPD and OPD services at each facility type. The majority of expenditures for both public and private facilities are spent for inpatient services; however, the majority of households seek outpatient care. The majority of households that seek health care abroad (73%) do so for inpatient care.

FIGURE 3.7: BREAKDOWN OF OOP EXPENDITURES AND MARKET SHARE BY PUBLIC, PRIVATE AND FACILITIES ABROAD, 2011–2012



3.6.4. WHICH PROVIDERS CONSUME MOPH FUNDS?

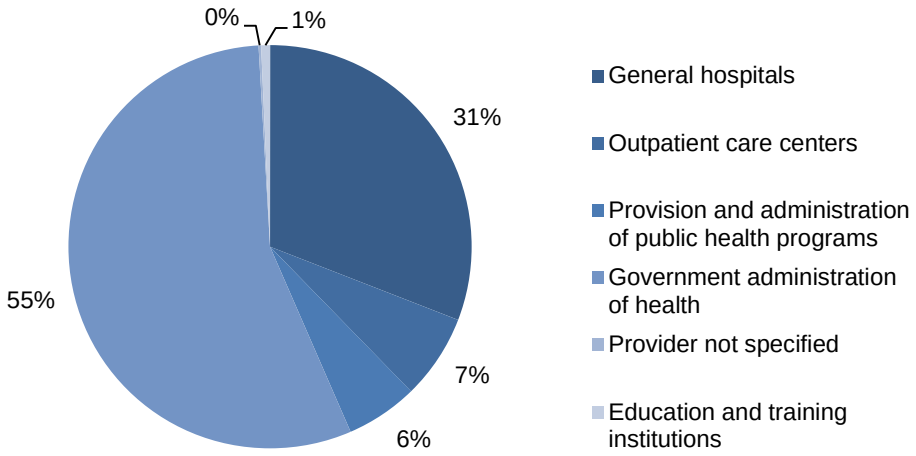
As described in Figure 3.8, general government administration of health was the largest provider of services using MoPH funds, accounting for 55.6 percent in 2011–2012. As noted above, general administration consists of costs at the central and provincial levels that are associated with the delivery of health services. This could include capacity building, training, and technical assistance for the MoPH aimed at improving the management of health programs at the central and provincial levels. General hospitals were the second greatest consumer with 30.9 percent of MoPH funds in 2011–2012. This represents a 5.1 percent increase from 2008–2009. Outpatient centers provided considerably less care using MoPH funds in 2011–2012, falling to 6.8 percent from 34 percent in 2008–2009. This could best be explained by an increase in utilization of private facilities for outpatient services, as evidenced by the findings in the NRVA. Furthermore, this could be indicative of changes in health-seeking behavior, including greater use of hospitals for outpatient services in urban areas.

Finally, it is worth mentioning that MoPH does allocate some funding (USD 1,157,897) toward institutions providing health-related services, including education and training institutions. The NHA allow governments to track spending on services that are considered health-related or goods and services that contribute to but are not directly intended to improve or maintain one's health. Since they are not direct health expenditures, they are not included in THE. They are, however, represented as part of the National Health Expenditure (NHE) for the MoPH.

TABLE 3.8: BREAKDOWN PROVIDERS OF MOPH FUNDS, 2011–2012

Distribution of Providers for MoPH Funds (USD)		
General hospitals	50,470,036	30.9%
Outpatient care centers	11,080,765	6.8%
Provision and administration of public health programs	9,416,405	5.8%
Government administration of health	90,831,376	55.6%
Provider not specified	329,000	0.2%
Total THE	**162,127,582**	**99.3%**
Education and training institutions	1,157,897	0.7%
Total NHE	**163,285,479**	**100.0%**

FIGURE 3.8: BREAKDOWN PROVIDERS OF MOPH FUNDS, 2011–2012



3.7. HEALTH CARE FUNCTIONS: WHAT SERVICES AND/OR PRODUCTS ARE PURCHASED WITH HEALTH FUNDS?

A health function is a good or service that is consumed by individuals to improve or maintain one's health. These functions generally include inpatient and outpatient curative care; ancillary services to health care; medical goods and pharmaceuticals; prevention and public health services; and health administration. The NHA also includes health-related functions such as education, training, and health research. These health-related functions are included as part of the NHE, but do not fall under THE as direct health expenditures.

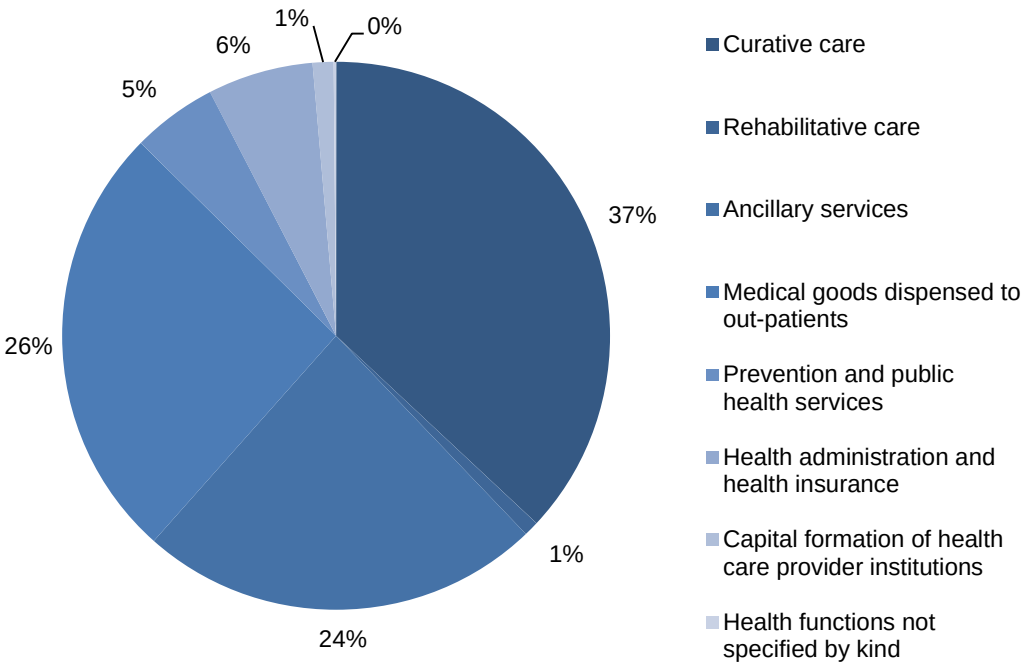
Table 3.9 below represents the breakdown of health functions for THE in 2011–2012. Services of curative care, including inpatient and outpatient services, accounted for 36.6 percent of THE. This represents a 22 percent decrease from 2008–2009. Medical goods

dispensed to outpatients accounted for 25.6 percent of THE in 2011–2012, which is a slight reduction from 28 percent three years prior. Ancillary services accounted for almost one-quarter of expenditures in 2011–2012—up from 0.04 percent in 2008–2009. This is due to a reconsideration and reclassification of these services from general outpatient services to its more appropriate code as ancillary services, likewise explaining the similarly proportioned decrease in curative services as a percentage of THE. Relative expenditures on prevention and public health services, as well as general health administration, remained roughly the same over the three-year period.

TABLE 3.9: BREAKDOWN OF HEALTH FUNCTIONS, 2011–2012

Function Distribution as a % of THE (USD)		
Curative care	554,892,675	36.6%
Inpatient curative care	322,110,499	58.0%
Outpatient curative care	232,782,176	42.0%
Rehabilitative care	13,061,535	0.9%
Ancillary services	356,130,855	23.5%
Medical goods dispensed to outpatients	387,689,137	25.6%
Prevention and public health services	75,131,516	5.0%
Health administration and health insurance	93,519,263	6.2%
Capital formation of health care provider institutions	18,437,307	1.2%
Health functions not specified by kind	2,113,657	0.1%
Total	**1,500,975,945**	**100%**

FIGURE 3.9: BREAKDOWN PROVIDERS OF MOPH FUNDS, 2011–2012



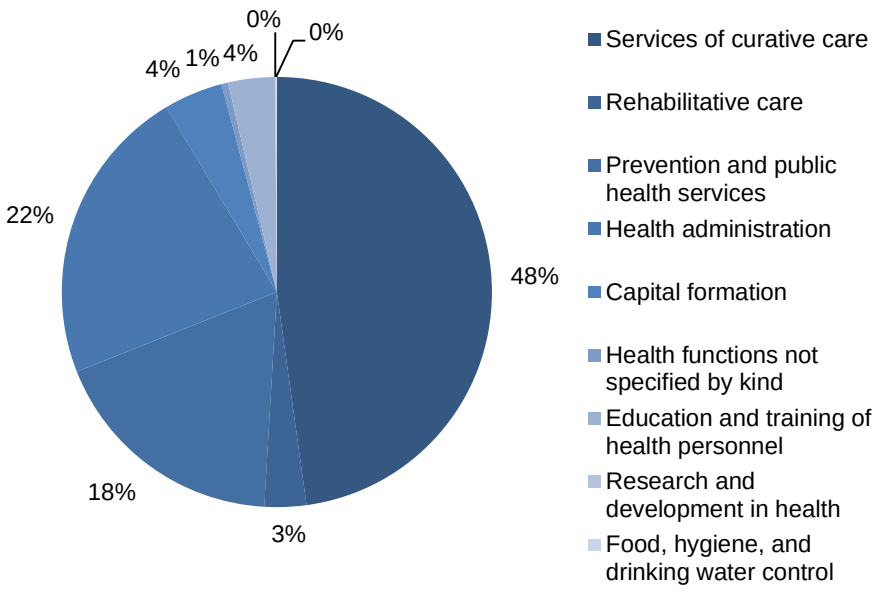
3.7.1. WHAT GOODS OR SERVICES ARE PURCHASED WITH FUNDING FROM THE CENTRAL GOVERNMENT AND INTERNATIONAL DONORS?

Table 3.10 and Figure 3.10 below describe the breakdown of funding on health functions by the central government and international donors only. Almost half of all expenditures (47.8%) were spent on curative care, including inpatient and outpatient services. This finding is as expected given the nationwide rollout of the BPHS and EPHS programs. The second greatest share of expenditures was for government administration of health, accounting for 22.4 percent of spending by the central government and other donors. This includes administrative costs required to run MoPH-funded programs. An additional 18 percent was spent on prevention and public health services. Finally, smaller portions of the central government and development partners' contributions were for other goods and services, including rehabilitative care and capital formation of health facilities.

TABLE 3.10: BREAKDOWN OF EXPENDITURES BY FUNCTION (EXCLUDING HOUSEHOLD OOP), 2011–2012

Services of curative care	199,158,298	47.8%
Rehabilitative care	13,061,535	3.1%
Prevention and public health services	75,131,516	18.0%
Health administration	93,519,263	22.4%
Capital formation	18,437,307	4.4%
Health functions not specified by kind	2,113,657	0.5%
Education and training of health personnel	14,565,775	3.5%
Research and development in health	200,952	0.0%
Food, hygiene, and drinking water control	437,143	0.1%
Total	**416,625,445**	**100.0%**

Figure 3.10: Breakdown of Expenditures by Function (Excluding Household OOP), 2011–2012



4. REPRODUCTIVE HEALTH SUBACCOUNT FINDINGS

4.1. SIGNIFICANCE OF RH FINDINGS

By conducting an RH subaccount application, the MoPH has demonstrated its commitment to monitoring and improving the health of women and children in Afghanistan. Identifying the key contributors to RH care as well as the services being provided helps policymakers assess and re-evaluate current health policies that affect the immediate health care needs of women and children. Subaccount findings can also help decisionmakers to more equitably allocate resources across the country, including more remote and insecure areas. The analysis of funding flows with respect to RH services has the ultimate goal of helping MoPH, donors, and international NGOs better deliver and manage the essential, life-sustaining services needed by women and children.

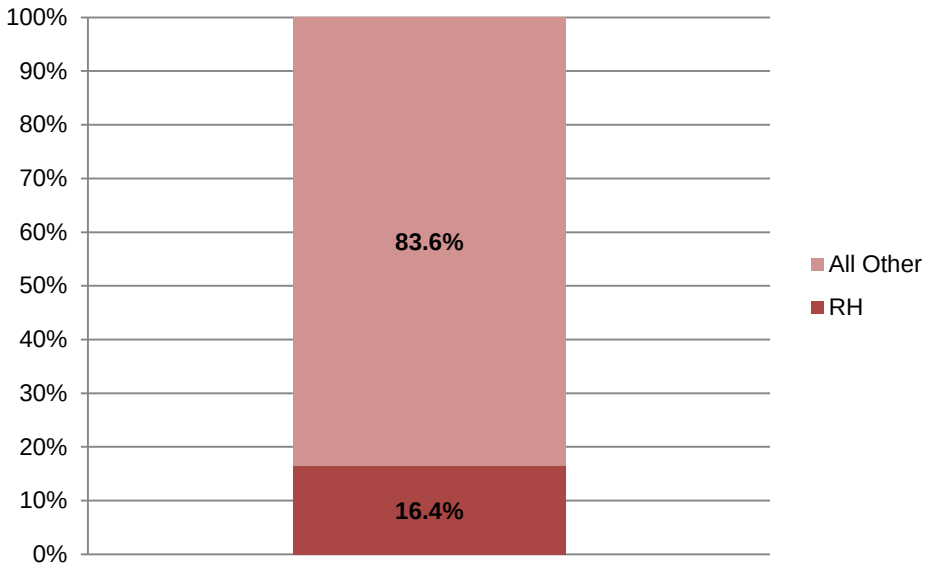
4.2. SUMMARY OF RH FINDINGS

The summary findings for Afghanistan's first RH subaccount are described below in Table 4.1 and subsequent sections. In 2011–2012, total health expenditure for RH (THE_{RH}) was USD 246,744,339. As shown in Figure 4.1, THE_{RH} accounted for 16.4 percent of THE in the general account. Aggregate spending on all other disease areas and interventions makes up the remaining 83.6 percent of THE. Total RH expenditures were USD 44 per woman of reproductive age (15–49 years old), with USD 35 per woman of reproductive age being financed by individual households. Similar to the general account, individual households were the main financier of RH in 2011–2012, funding 78.5 percent of THE_{RH}. All household expenditures for RH were again expressed as OOP payments made to service providers at the point of delivery. International donors contributed significant funding for RH as well. The central government financed just under 3 percent of THE_{RH}, though it played a much larger role as a manager of RH funds. Outpatient centers and providers of medical goods received the greatest amount of funds for the provision of RH services. In line with this finding, curative care and medical goods were the most purchased goods and services for RH care in 2011–2012.

TABLE 4.1: SUMMARY OF RH STATISTICS, 2011–2012

RH Indicators	2011–2012
Total population of reproductive age (15-49)	5,595,929
Total RH (THE_{RH}) health expenditure (USD)	246,744,339
RH expenditure per woman of reproductive age (USD)	44
RH expenditure as % of GDP	1.3%
RH expenditure as % of General THE	16.4%
Financing Source as a % of THE_{RH}	
Central government	2.7%
Private	78.5%
Households	78.5%
Non-profits serving households	0.01%
Rest of the World	18.8%
Household (HH) Spending for RH	
Total HH (OOP) spending as % of THE_{RH}	78.5%
Total HH (OOP) spending per woman of reproductive age	35
Financing Agent Distribution as a % of THE_{RH}	
Central government	11.3%
Household OOP	78.5%
Non-profits serving households	0.01%
Rest of the World	10.2%
Provider Distribution as a % of THE_{RH}	
Hospitals	19.9%
Outpatient care centers	32.8%
Retail sale and other providers of medical goods	29.0%
Provision and administration of public health programs	3.0%
General health administration	7.1%
All other industries	8.2%
Function Distribution as a % of THE_{RH}	
Curative care	
Inpatient care	19.1%
Outpatient care	22.8%
Ancillary services	24.3%
Medical goods dispensed to outpatients	29.0%
Prevention and public health services	3.0%
Health administration	1.7%

FIGURE 4.1: RH AS A PERCENTAGE OF THE, 2011–2012



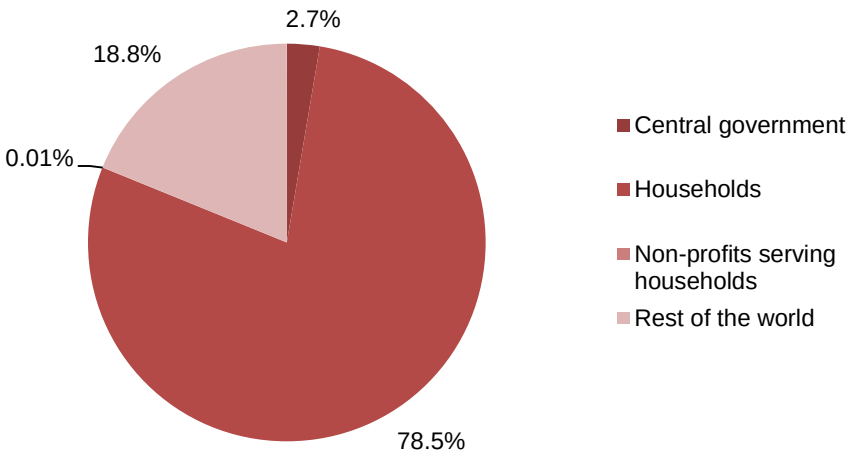
4.3. FINANCING SOURCES: WHO PAYS FOR RH CARE?

In terms of financing sources, findings of the RH subaccount were not unlike those of the general account. As shown in Table 4.2 and Figure 4.2, in 2011–2012, individual households financed more than three-quarters of THE_{RH}. International donors also contributed a significant portion at nearly one-fifth of THE_{RH}. The central government financed less than 3 percent, while non-profit organizations serving households played an extremely minor role, funding 0.01 percent of THE_{RH}.

TABLE 4.2: BREAKDOWN OF THE_{RH} BY SOURCE, 2011–2012

Financing Source as a % of THE_{RH}		
Central government	6,577,377	2.7%
Private sources	193,679,467	78.5%
Households	193,650,212	78.5%
Non-profits serving households	29,255	0.01%
Rest of the world	46,487,494	18.8%

FIGURE 4.2: BREAKDOWN OF THE_{RH} BY SOURCE, 2011–2012



4.3.1. HOUSEHOLD EXPENDITURES ON RH

As the main financing source, households contributed USD 193,650,212 to THE_{RH} in 2011–2012 (78.5%). The household OOP spending per woman of reproductive age was USD 35. When compared with USD 44 for total RH spending per woman ages 15–49 from all sources, it is clear that households bear a significant burden for RH care.

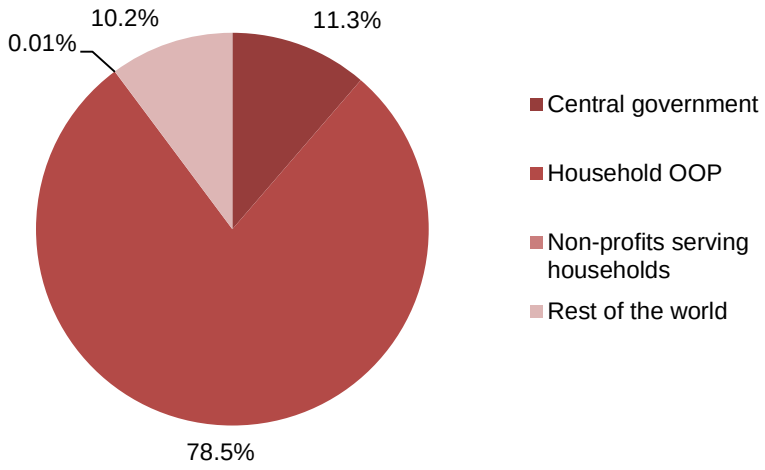
4.4. FINANCING AGENTS

The central government played a more significant role in RH as a manager of RH funds. Through the MoPH, the central government controlled 11.3 percent of THE_{RH} in 2011–2012, which was slightly greater than 10.2 percent of THE_{RH} managed by international donors. Many donors channel funds through the MoPH, which works to equitably allocate resources for RH throughout the country. Despite the central government's amplified role as financing agent, individual household OOP payments accounted for the greatest portion of RH funds, with 78.5 percent of THE_{RH}. The breakdown of financing agents for RH expenditures is described in Table 4.3 and Figure 4.3.

TABLE 4.3: BREAKDOWN OF THE_{RH} BY FINANCING AGENT, 2011–2012

Financing Agent Distribution as a % of THE_{RH}		
Central government	27,923,925	11.3%
Household OOP	193,650,212	78.5%
Non-profits serving households	29,255	0.01%
Rest of the world	25,140,947	10.2%

FIGURE 4.3: BREAKDOWN OF THE_{RH} BY FINANCING AGENT, 2011–2012



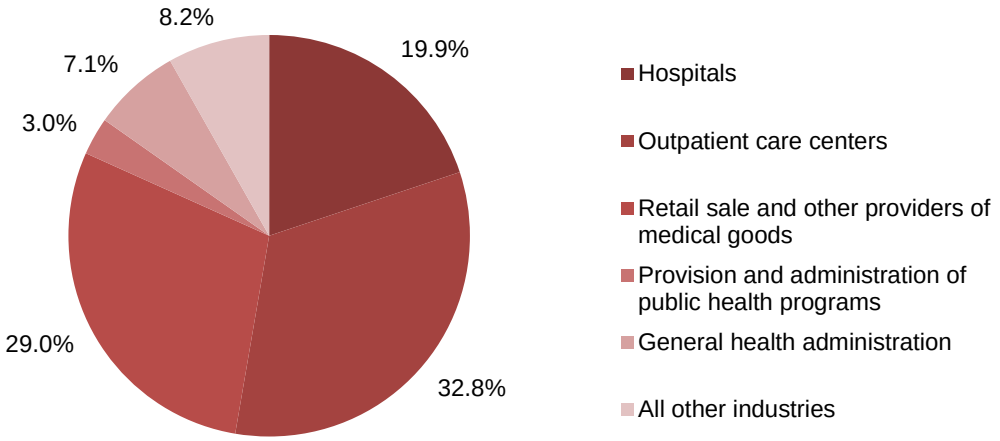
4.5. PROVIDERS

As shown in Table 4.4 and Figure 4.4, a number of providers are responsible for RH care. Outpatient care centers, including medical and diagnostic laboratories, were the largest provider of RH services, providing 32.8 percent of THE_{RH} in 2011–2012. Retail sale and other providers of medical goods were the second greatest provider of THE_{RH} with 29 percent, followed by hospitals with 19.9 percent. About 7 percent of THE_{RH} was attributed to general health administration, while an additional 8.2 percent was provided by other industries as secondary providers of health care. Finally, only 3 percent of THE_{RH} was classified as provision and administration of public health programs.

TABLE 4.4: BREAKDOWN OF THE_{RH} BY PROVIDER, 2011–2012

Provider Distribution as a % of THE_{RH}		
Hospitals	49,019,370	19.9%
Outpatient care centers	81,041,266	32.8%
Retail sale and other providers of medical goods	71,604,260	29.0%
Provision and administration of public health programs	7,443,773	3.0%
General health administration	17,399,639	7.1%
All other industries	20,236,030	8.2%

FIGURE 4.4: BREAKDOWN OF THE_{RH} BY PROVIDER, 2011–2012



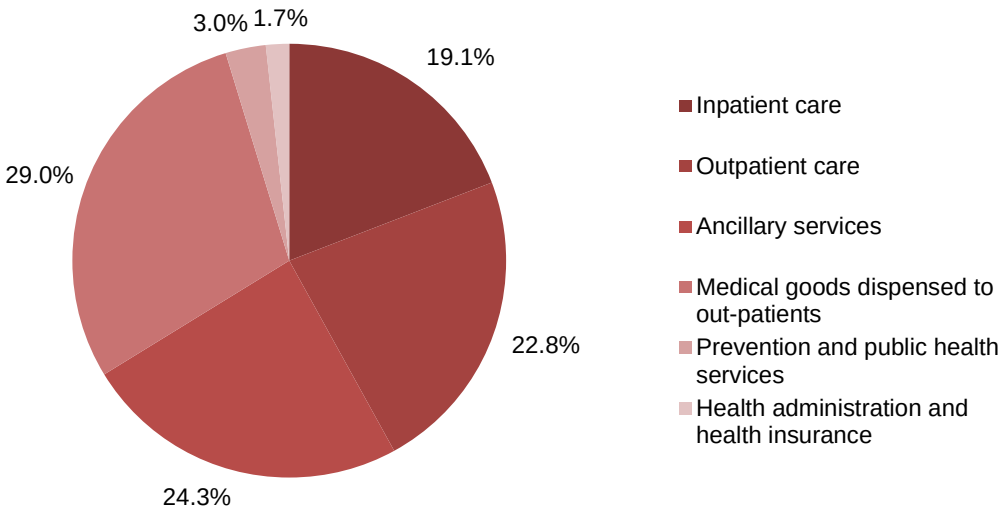
4.6. HEALTH FUNCTIONS

Table 4.5 and Figure 4.5 describe the distribution of THE_{RH} by health function or the goods and services purchased with RH funds. Curative services accounted for the greatest portion of THE_{RH}, with 19.1 percent for inpatient care such as labor and delivery and 22.8 percent for outpatient services such as antenatal appointments. Medical goods dispensed to outpatients were the second largest health function, accounting for 29 percent of THE_{RH}. This includes all prescribed medicine or oral contraceptives. However, family planning services are typically considered under prevention and public health services, which account for just 3 percent of THE_{RH}. Finally, 24.3 percent of THE_{RH} was spent on ancillary services, which includes medical and diagnostic imaging, transport, and other supporting costs for RH.

TABLE 4.5: BREAKDOWN OF THE_{RH} BY HEALTH FUNCTION, 2011–2012

Function Distribution as a % of THERH		
Curative care		
Inpatient care	47,242,711	19.1%
Outpatient care	56,289,700	22.8%
Ancillary services	59,897,927	24.3%
Medical goods dispensed to outpatients	71,604,260	29.0%
Prevention and public health services	7,443,773	3.0%
Health administration	4,265,968	1.7%

FIGURE 4.5: BREAKDOWN OF THE_{RH} BY HEALTH FUNCTION, 2011–2012



5. CONCLUSIONS & POLICY IMPLICATIONS

5.1. CONCLUSIONS

5.1.1. GENERAL NHA

As the public sector focuses on reform after several decades of conflict, there have been noteworthy improvements in the overall economy as well as increased spending in the health sector. However, despite absolute increases in health spending, THE as a percentage of GDP decreased 2 percentage points over three years, and government expenditure on health as a percentage of total government expenditure has not improved. The burden of financing the health system falls largely to individual households. While households' percentage of THE dropped slightly over the three-year period, absolute spending increased from USD 787,076,258 to USD 1,099,542,464, representing a 39.7 percent increase. What is more alarming is that households must finance their own health care without the protection of insurance. These direct OOP payments pose great concerns of extreme inequity of using essential health services among the poorest households. The central government should therefore look to increase its role as health financier and enlist the private sector to take a more active role as well. After all, donor support is considered unsustainable and should not be relied on in the long term.

Retail sale and other providers of medical goods provided the largest portion of services in 2011–2012. This finding is indicative of the low quality of health services in the public sector, the lack of medical supplies and pharmaceuticals available at health facilities across the country, for reasons unclear, and other access barriers to formal health facilties. There may be a general unavailability of medicines, or the lack of medical supplies and pharmaceuticals may be due to over-prescription by doctors or self-prescription by patients, commonly recognized as problems. Inpatients are often subject to visiting private pharmacies to purchase their own medication and then return to the hospital for treatment. Stockouts and shortages of medical supplies and pharmaceuticals at public facilities can serve as a motivation for individuals to seek care at private facilities, despite that the BPHS and EPHS offer free health services.

Curative services, including inpatient and outpatient care, accounted for the largest portion of services provided to consumers. Prevention and public health services, on the other hand, were underutilized (or underestimated, as described in section 5.2, recommendation point 4). This is not necessarily surprising given that BPHS and EPHS are the MoPH's flagship efforts to expand coverage to households. Furthermore, this makes sense in the absence of insurance networks in Afghanistan and the high burden placed on households. Many cannot afford to seek preventive care and therefore only seek care when treatment is critically important.

5.1.2. RH SUBACCOUNT

Afghanistan spent 16.4 percent of THE on RH in 2011–2012. The proportion of spending on RH in Afghanistan is on par with spending in other countries that have successfully completed RH subaccounts; for example, Kenya spent 13.8 percent of THE on RH in 2008/09, while Tanzania spent 17.9 percent in 2009/2010. This finding may instead be more meaningful to policymakers in Afghanistan if it were compared to a national costing study for

RH. In Namibia, for example, policymakers used findings of their 2009/2010 RH subaccount to determine that their Maternal and Child Health Roadmap was significantly underfunded. Likewise, Afghanistan can set priorities for RH spending and use subaccount findings to determine whether goals are being met. Based on the country's maternal and child health profile alone, more must be done to improve RH outcomes. This may involve ramping up spending for RH; alternatively, an evidence-based reallocation of funding may be in order.

The central government may need to consider increasing investments in RH. In financing just 2.7 percent of THE_{RH}, the burden falls to households and international donors. Households need more support in financing all health care, not only RH. While donors are providing significant support at present, these entities are not considered sustainable or reliable sources of funding given the current political economy. The central government plays a greater role as manager of RH funds, as it often receives sums of money from international donors, which they are free to allocate to RH services. However, households continue to control the vast majority of RH funds.

The greatest provider of RH care was outpatient centers. Again, this seems reasonable given the expansive reach of BPHS, which includes both antenatal and prenatal services. Curative services accounted for the greatest portion of THE_{RH}, with 19.1 percent for inpatient care such as labor and delivery and 22.8 percent for outpatient services such as antenatal appointments. Medical goods dispensed to outpatients were the second largest health function, accounting for 29 percent of THE_{RH}. This includes all prescribed medicine or oral contraceptives, vitamins, nutritional supplements, etc., which may seemingly indicate that many women are using some form of birth control. However, this is likely not the case but rather is more reflective of the NHA classifications. A more detailed study on contraceptive use would need to be conducted.

5.2. RECOMMENDATIONS

The second round of NHA provided rich and timely data that can be used to evaluate current and future health policies related to overall spending and RH care. The findings point to potential vulnerabilities in the health system, as well as opportunities for growth and improvement. A number of policy considerations are discussed below.

- **Continue investigating new revenue generation strategies for the health sector:** In Afghanistan, the health spending of $56/capita remains low. Public expenditures in general are very low largely due to the country's inability to generate domestic revenue through traditional methods such as tax collection. Furthermore, a very small share of public expenditure is devoted to health. In 2008, almost 40 percent of Afghanistan's population was between 10 and 29 years old (APHI/MoPH et al., 2010). This "youth bulge" suggests that more people will be entering their reproductive years and having children, serving to increase the burden on health care and other social services. With donor funding inevitably being reduced over time, it is within the central government's best interest to explore new revenue structures with funding earmarked for the health sector.

  The existing 4.2 percent government budgetary contribution is clearly insufficient—health care spending should be seen as an investment in economic growth. Individuals will live longer and retain their ability to be productive members of society.

Ultimately, there is a need to strengthen the relationship between the MoPH and the MoF. Unless the MoPH can make an effective case for prioritization of health programs, it will be unable to capture as much funding for the sector as might be possible. Because the MoF often prioritizes the budget for economic-oriented activities and pays less attention to the needs of the health sector and the negative consequences of underfunding, the MoPH will need to put health in the development framework, linking health indicators to economic growth. In addition, the GIRoA should institutionalize a forum to promote dialogue between the two ministries to increase mutual understanding and align goals.

- **Implement a risk protection mechanism for households:** Households in Afghanistan spend on average USD 41 per capita on health. Without any risk protection mechanisms, such high expenses relative to GDP/capita pose severe barriers to accessing health care for individual households and create extreme inequity in using health services among the population, such as the rural poor, which are the most vulnerable. Catastrophic payments, in particular, can push households into debt, force them to sell assets, and negotiate high-interest payment schemes with providers. In the long term, some form of financial risk protection should be introduced. For example, increased government allocation and expenditure to the health sector, community-based financing schemes, limited social insurance programs, or some combination could mitigate some of these effects and increase access to treatment. Feasibility studies should be undertaken to assess the financial and structural viability as well as community receptiveness to these interventions.

  At the hospital level, implementation of risk protection mechanisms such as health insurance may entail the introduction of co-payments for services to reduce moral hazard and equity funds for the most poor to mitigate the impact of user fees on the poor. All national hospitals are funded by the government and free of charge, which results in low efficiency and low quality. The introduction of a co-payment would allow hospitals to generate revenue, while create incentives to improve the quality of services through proper use of the revenue. The MoPH should make further efforts to sensitize stakeholders (MoF, MoJ, Parliament) to concepts of risk protection, co-payments, and other health financing schemes.

- **Promote rational medicine use and improve the drug supply:** Pharmaceuticals and other medical non-durables make up the bulk of household health expenses with a significant proportion dispensed through pharmacies and retail shops. Other costing studies showed that public allocation to medicine is low compared to other goods and services (GIRoA, 2012d). Stockouts occur often in public health facilities and drive patients to seek care in private settings. There are numerous reasons why this might be the case. First, not only are doctors thought to frequently overprescribe medications, but patients often demand medication that is not clinically indicated. Overuse of medicines by patients is commonly accepted as patients also ask private pharmacies to prescribe medicines, despite that the majority of pharmacies do not have qualified pharmacists on staff. (A significant amount of pharmaceutical products are also thought to be purchased through illegitimate channels). The MoPH must further its plans to survey the retail sector and formulate effective regulatory functions.

- **Improve understanding of investments in preventive care:** Under the BPHS and EPHS, physicians and other medical personnel conduct certain preventive activities, including counseling, screening, vaccinations, and blood pressure, cholesterol, and diabetes tests. However, the time and resources spent on these are considered as curative under the NHA because they are provided as inpatient and outpatient services. Thus, government expenditure on preventive health is likely to be underestimated. An in-depth study of the BPHS/EPHS may be able to more finely distinguish spending on preventive and curative services. The same underestimation applies for household expenditures on preventive care as questions included in the NRVA survey were primarily directed at spending on curative services. Future household surveys can be improved by asking for information on preventive services received.

  Similarly, spending on RH preventive services such as family planning and counseling is likely underrepresented in this study. Aside from organizations dedicated to providing RH public health services specifically, it was challenging to distill the RH preventive and public health components from the secondary datasets utilized for the NHA. Future NHAs using primary data from both institutions and households will more finely tune the national expenditures surrounding preventive service for RH.

- **Implement the MoPH Private Sector Strategy and regulate the private market:** With health care demands out-pacing the supply of services and available resources, the BPHS and EPHS are incapable of providing treatment to all. Because the current limited capacity and sustainability of the BPHS and EPHS is wholly dependent on donor funding, it is important that the MoPH begin leveraging the private sector. Achieving public health goals will require more effective use of private resources; therefore, it is recommended that the MoPH Private Sector Strategy be implemented to increase the private sector's overall contribution in the health sector. Engaging and building partnerships with the private sector will enable the public sector to ensure better quality and best practices across providers nationwide. It is recommended that the government provide an amiable environment to foster competition among the private sector or between the public and private sector and ensure the quality of services delivered by both. Furthermore, better engagement of the private health sector can help alleviate the burden of financing the health system on the public sector.

- **Invest in capital formation of the health sector:** This NHA found that less than 2 percent of THE was dedicated to capital formation in 2011–2012. Capital formation includes the building of health facilities as well as the purchase of equipment necessary to deliver care. Outdated equipment and the overall lack of essential supplies surely detract from the quality of care provided at public facilities and serve, in part, as a motivation for seeking care at private facilities. A reallocation of the MoPH's budget toward capital formation may help improve results in diagnostic and treatment services at public facilities and contribute to long-term sustainability of service provision. Alternatively, public-private partnerships may be considered for diagnostic services as they contribute to a bulk of the capital costs, particularly in larger tertiary level hospitals.

- **Continue to advocate for the institutionalization of NHA:** As noted throughout the report, the MoPH has made significant efforts to produce the first two rounds of NHA, and the institutionalization process is underway. The MoPH should continue to advocate for the NHA framework, including its incorporation in the government's annual budget. The NHA technical team can look forward to improving the method and systems for collecting and analyzing data while expanding to new subaccount areas of interest, such as child health. Section 6 provides further detail on the MoPH's NHA institutionalization efforts.

6. INSTITUTIONALIZING NHA

As demonstrated in this report, the NHA is a powerful framework for capturing and analyzing health expenditure data. When such data are collected on a regular basis, policymakers can access relevant information to guide strategic planning processes, identify gaps in funding, improve allocation of resources across sectors, and determine where investments and national objectives may or may not be in line.

The benefits of NHA are clear; however, there are many challenges to producing and institutionalizing NHA. Afghanistan has overcome the first challenge, which is finding an institutional home for the methodology in the HEFD of the MoPH. The NHA technical team now has several years of experience with the framework and has successfully produced two estimations. However, technical expertise is not enough. The NHA team requires regularly produced high-quality data from all development partners, ministries, and households in order to accurately capture health funding from year to year. Furthermore, NHA can be costly and time consuming; therefore, the MoPH is keen to explore technologies and partnerships that streamline data collection and analysis processes.

Against this background, the MoPH has been working to develop an Expenditure Management Information System (EMIS) streamline the data collection process. The EMIS is a standard mechanism within the MoPH that, once implemented, stakeholders will utilize to easily report their health expenditure data on a regular basis. Necessary information, in turn, will be made readily accessible to the NHA technical team. Similarly, the MoPH is working to improve the content of household expenditure data as well as the process for collecting it. The CSO conducts nationwide multi-purpose household surveys on a regular basis. For the MoPH to collect accurate and high-quality data on OOP expenditures, a health expenditure module was incorporated into the CSO's NRVA survey for the current NHA. As a permanent module in the survey, the NRVA would collect regular, relevant, and comparable data on household OOP expenditures on health. Therefore, the CSO and MoPH formed a partnership via a memorandum of understanding (MoU) in September 2011 that serves as a vehicle through which the two entities will work jointly on NHA institutionalization activities. However, it is imperative that active communication between the MoPH and CSO on the design of the survey continues—to ensure estimates are valid and representative and to allow for comparability over time. Improved coordination is also necessary to ensure timely dissemination of results.

Despite the challenges of producing NHA estimations, Afghanistan has demonstrated its commitment to using health financing data to move from evidence to policy. The NHA technical team plans to be trained on the recently updated NHA methodology, including the Systems of Health Accounts (SHA 2011), prior to the next NHA, which is programmed for 2014.

ANNEX A. CLASSIFICATION OF HEALTH EXPENDITURES

The classifications used to estimate health expenditures in Afghanistan are in line with the *Guide to Producing National Health Accounts, with Special Application for Low-income and Middle-income Countries,* which is an extension of the International Classification of Health Accounts (ICHA) found in *A System of Health Accounts (SHA)* (Organization for Economic Cooperation and Development [OECD] 2000):

SOURCES AND AGENTS

"Financing sources" is a term used for the entities that provide resources to "financing agents" to be pooled and distributed. In the case of households, in Afghanistan, the financing source and agent are considered to be the same. Because the majority of financing sources are clearly defined by name, there will no further elaboration here.

Please note that **FS.3 Rest of the world** comprises direct funding from donors, as well as donor assistance via the government. **HF.3 Rest of the world** is comprised of only direct funding from donors.

PROVIDERS

- **HP.1. Hospitals** are licensed establishments primarily engaged in providing medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Public hospitals include national, regional, provincial, and district hospitals.

- **HP.3. Ambulatory care services** are establishments primarily engaged in providing health care services directly to outpatients who do not require inpatient services. Public outpatient care centers include mobile clinics, health posts, sub-health centers, basic health centers, and comprehensive health centers/polyclinics. Private outpatient care includes private clinics, private doctor's offices, and traditional practitioners.

- **HP.4. Retail sale and other providers of medical goods** sell medical goods to the general public for personal or household consumption or utilization. These do not include pharmacies within inpatient and outpatient facilities.

- **HP.5. Provision and administration of public health programs** include government and private administration and provision of public health programs such as health promotion and protection programs (for example, vaccination campaigns).

- **HP.6. General health administration** includes the MoPH, provisional health offices, and other ministries who receive funds for administrative purposes (e.g., wages, overhead, development of information systems, or training activities).

- **HP.7. All other industries** are those not classified elsewhere which provide health care as secondary producers or other producers. These may include occupational health care

services not provided in separate health care establishments (all industries), military health services not provided in separate health care establishments, school health services; as well as counselling centers, charities, foundations, and mosques.

- **HP.8. Institutions providing health-related services** include research centers, academic institutions, and similar entities.

FUNCTIONS

Service delivery is separated into three main categories within the NHA framework: "curative" medical care, "rehabilitative care," and "prevention and public health."

- **HC.1. Curative care** is considered as care "on which the principal medical intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury, or to protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function." HC 1.1. Inpatient curative care includes expenses incurred during an overnight stay at a hospital; while HC 1.3. Outpatient curative care refers to services delivered to outpatients by physicians in establishments of the ambulatory health care industry or in specialized outpatient wards of hospitals. In Afghanistan, inpatient and outpatient curative care are offered at all levels of the health systems—that is in both BPHS and EPHS facilities. As it was not possible to disaggregate between inpatient and outpatient services at the facility level, all such expenditures have been aggregated under HC 1. Curative care. Included within these are administrative expenditures *incurred at the facility level*, including staff salaries, laboratory and x-rays, as well as expenditures related to pharmaceuticals and medical goods used in the course of treatment. **All BPHS and EPHS activities are captured under curative care.**

- **HC.2. Services of rehabilitative care** are considered services where the emphasis lies on improving the functional levels of the persons served and where the functional limitations are either due to a recent event of illness or injury or are of a recurrent nature (regression or progression). Again, in Afghanistan, episodes of rehabilitative care were treated in the course of curative care and for this reason could not be disaggregated.

- **HC.4. Ancillary services** comprise a variety of services, mainly performed by paramedical or medical technical personnel with or without the direct supervision of a medical doctor, such as laboratory, diagnosis imaging, and patient transport (ambulance services).

- **HC.5. Pharmaceuticals and non-medical durables** include all expenditures at retail pharmacies and other suppliers of medical goods, and are *separate* from costs incurred at hospitals and outpatient care centers. In other words, HC 5 captures *only* those expenditures incurred *outside of a health facility*. At the provider level, HP 4. Retail sale and other providers of medical goods refer only to retail pharmacies and excludes those pharmacies and suppliers embedded within a hospital facility.

- **HC.6. Prevention and public health** does not include preventive care provided as part of outpatient treatment. Rather it encompasses services "designed to enhance the health status of the population as distinct from the curative services, which repair health dysfunction." In Afghanistan, typical programs that fall under this category are vaccination campaigns. This means that items such as HC 6.1. Maternal and child health care and HC 6.3. Prevention of communicable diseases refer only to programmatic expenditures and not those services delivered as part of outpatient care.

- **HC.7. Health administration and insurance** includes all activities such as formulation, administration, co-ordination, and monitoring of overall health policies, plans, programs, and budgets as well as training and institutional capacity building of civil servants (non-medical personnel). While all costs related to these activities and occurring at the central level are captured under HC. 7, those occurring at the facility level are included under HC.1. Curative Care. As there were no recognized health insurance providers in Afghanistan in 2008–2009, this category has been omitted for the purposes of this report.

- **HC.R.1. Capital formation** comprises "gross capital formation of domestic health care provider institutions excluding those listed under HP.4 Retail sale and other providers of medical goods." This mainly includes spending on items such as the construction of buildings and equipment for health providers. For Afghanistan, the majority of ISAF health sector investments are captured under this category.

- **HC.R.2. Education and training of health personnel** comprises government and private provision of education and training of health personnel, including the administration, inspection, or support of institutions providing education and training of health personnel. For example, support to Kabul Medical University and local nursing schools are included under this category.

- **HC.nsk. Not specified by any kind** are those expenditures that cannot be classified under any particular classification or the expenditure is too small (less than 2 percent of THE) to disaggregate. In Afghanistan, this refers to the establishment of an Injectable Liquid (IV Solution) Producing Factory.

ANNEX B. GENERAL NHA MATRICES

TABLE B1. AFGHANISTAN GENERAL NHA—FINANCING SOURCE BY FINANCING AGENT (FSXHF), 2011–2012

FSxHF	FS.1.1.1 Central government revenue	FS.2.2 Household funds	FS.2.3 Non-profit institutions serving individuals	FS.3 Rest of the world funds	Row total	HF % of THE
HF.1.1.1.1 Ministry of Public Health	68,516,673			93,610,910	162,127,582	10.8%
HF.1.1.1.2 Ministry of Defence	8,489,362				8,489,362	0.6%
HF.1.1.1.3 Ministry of Interior Affairs	5,990,485				5,990,485	0.4%
HF.1.1.1.4 Ministry of Higher Education	971,441				971,441	0.1%
HF.1.1.1.5 Ministry of Education	180,133				180,133	0.0%
HF.2.3 Private households' out-of-pocket payment		1,099,542,464			1,099,542,464	73.3%
HF.2.4 Non-profit institutions serving households (other than social insurance)			4,817,021		4,817,021	0.3%
HF.3 Rest of the world				218,857,457	218,857,457	14.6%
Column Total (THE)	**84,148,093**	**1,099,542,464**	**4,817,021**	**312,468,367**	**1,500,975,945**	**100.0%**
HF.Health-related	4,859,926			10,343,944	15,203,870	
Column Total (NHE)	**89,008,019**	**1,099,542,464**	**4,817,021**	**322,812,310**	**1,516,179,814**	
FS % of THE	**5.6%**	**73.3%**	**0.3%**	**20.8%**	**100.0%**	

TABLE B2. AFGHANISTAN GENERAL NHA—FINANCING AGENT BY PROVIDER (HFXHP), 2011–2012

HFxHP	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defence	HF.1.1.1.3 Ministry of Interior Affairs	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.5 Ministry of Education	HF.2.3 Private households' out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HP % of THE
HP.1.1 General hospitals	49,109,036	7,957,447	4,081,026	971,441		243,505,175	3,511,064	42,006,269	351,141,458	23.4%
HP.1.2 Mental health and substance abuse hospitals	1,361,000							2,011,263	3,372,263	0.2%
HP.1.3 Specialty (other than mental health and substance abuse) hospitals								11,570,274	11,570,274	0.8%
HP.3.4.2 Outpatient mental health and substance abuse centers								840,523	840,523	0.1%
HP.3.4.4 Dialysis care centers	84,800								84,800	0.0%
HP.3.4.9 All other outpatient community and other integrated care centers	10,995,965				11,906	112,229,202	117,021	44,379,863	167,733,957	11.2%
HP.3.5 Medical and diagnostic laboratories						211,587,782			211,587,782	14.1%
HP.4.2 Retail sale and other suppliers of optical glasses and other vision products						4,946,536			4,946,536	0.3%
HP.4.3 Retail sale and other suppliers of hearing aids						1,439,660			1,439,660	0.1%

HFxHP	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defence	HF.1.1.1.3 Ministry of Interior Affairs	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.5 Ministry of Education	HF.2.3 Private households' out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HP % of THE
HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods						381,291,035			381,291,035	25.4%
HP.5 Provision and administration of public health programs	9,416,405							65,954,887	75,371,292	5.0%
HP.6.1. Government administration of health	90,831,376	531,915	1,909,458		168,227		1,188,936	47,802,075	142,431,988	9.5%
HP.6.9 All other providers of health administration								4,292,303	4,292,303	0.3%
HP.7.3 All other industries as secondary producers of health care						144,543,073			144,543,073	9.6%
HP.nsk Provider not specified by kind	329,000								329,000	0.0%
Column Total (THE)	**162,127,582**	**8,489,362**	**5,990,485**	**971,441**	**180,133**	**1,099,542,464**	**4,817,021**	**218,857,457**	**1,500,975,945**	**100.0%**
HP.8.1 Research institutions								188,768	188,768	
HP.8.2 Education and training institutions	1,157,897	63,830		4,796,096				8,560,136	14,577,958	
HP.8.3 Other institutions providing health-related services								437,143	437,143	
Column Total (NHE)	**163,285,479**	**8,553,192**	**5,990,485**	**5,767,537**	**180,133**	**1,099,542,464**	**4,817,021**	**228,043,504**	**1,516,179,814**	

TABLE B3. AFGHANISTAN GENERAL NHA—PROVIDER BY HEALTH FUNCTION (HPXHC), 2011–2012

HPxHC	HP.1.1 General hospitals	HP.3 Providers of ambulatory health care	HP.3.5 Medical and diagnostic laboratories	HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administra-tion of public health programs	HP.6 General health administra-tion	HP.7.3 All other industries as secondary producers of health care	HP.nsk Provider not specified by kind	Row total (THE)	HP.8 Institu-tions providing health related services	Row total (NHE)	HC % of THE
HC.1.1 Inpatient curative care	333,144,454								333,144,454			22.2%
HC.1.3 Outpatient curative care (subaccount specific)	19,091,529	163,183,543				52,534,685			234,809,756			15.6%
HC.4 Ancillary services to medical care			211,587,782				144,543,073		356,130,855			23.7%
HC.5 Medical goods dispensed to outpatients		11,906		387,677,232					387,689,137			25.8%
HC.6 Prevention and public health services					75,131,516				75,131,516			5.0%

HPxHC	HP.1.1 General hospitals	HP.3 Providers of ambulatory health care	HP.3.5 Medical and diagnostic laboratories	HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administra-tion of public health programs	HP.6 General health administra-tion	HP.7.3 All other industries as secondary producers of health care	HP.nsk Provider not specified by kind	Row total (THE)	HP.8 Institu-tions providing health related services	Row total (NHE)	HC % of THE
HC.7 General government admin. of health (except social security) (subaccount specific)	52,678	1,150,859			239,776	92,075,951			93,519,263			6.2%
HC.nsk Health functions not specified by kind						2,113,657			2,113,657			0.1%
HC.R.1.99 Other capital formation of health care provider institutions	13,795,334	4,312,973						329,000	18,437,307			1.2%
Column Total (THE)	**366,083,995**	**168,659,280**	**211,587,782**	**387,677,232**	**75,371,292**	**146,724,292**	**144,543,073**	**329,000**	**1,500,975,945**			**100%**

HPxHC	HP.1.1 General hospitals	HP.3 Providers of ambulatory health care	HP.3.5 Medical and diagnostic laboratories	HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administra-tion of public health programs	HP.6 General health administra-tion	HP.7.3 All other industries as secondary producers of health care	HP.nsk Provider not specified by kind	Row total (THE)	HP.8 Institu-tions providing health related services	Row total (NHE)	HC % of THE
HC.R.2 Education and training of health personnel (subaccount specific)										14,565,775	14,565,775	
HC.R.3.99 Other Research and develop-ment in health										200,952	200,952	
HC.R.4.99 Other food, hygiene, and drinking water control										437,143	437142.92	
Column Total (NHE)										**15,203,870**	**1,516,179,815**	
HP % of THE	**24.4%**	**11.2%**	**14.1%**	**25.8%**	**5.0%**	**9.8%**	**9.6%**	**0.0%**	**100.0%**			

Table B4. Afghanistan General NHA—Financing Agent by Health Function (HFXHC), 2011–2012

HFxHC	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defence	HF.1.1.1.3 Ministry of Interior Affairs	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.5 Ministry of Education	HF.2.3 Private households' out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HC % of THE
HC.1.1 Inpatient curative care (subaccount specific)	7,097,252							6,054,735	13,151,987	0.9%
HC.1.1.99 Other Inpatient curative care	25,303,864	7,468,085	1,796,930	738,295		243,505,175	3,445,702	26,700,461	308,958,512	20.6%
HC.1.3 Outpatient curative care (subaccount specific)	16,271,099						29,255	11,932,045	28,232,399	1.9%
HC.1.3.9 All other outpatient curative care	59,893,751			233,146		112,229,202	153,128	32,040,550	204,549,777	13.6%
HC.2.1 Inpatient rehabilitative care								11,033,955	11,033,955	0.7%
HC.2.2 Day cases of rehabilitative care								152,335	152,335	0.0%
HC.2.3 Outpatient rehabilitative care								1,875,245	1,875,245	0.1%
HC.4.3 Patient transport and emergency rescue						75,579,594			75,579,594	5.0%
HC.4.9 All other miscellaneous ancillary services						280,551,260			280,551,260	18.7%
HC.5.1.1 Prescribed medicines					11,906	381,291,035			381,302,940	25.4%
HC.5.2.1 Glasses and other vision products						4,946,536			4,946,536	0.3%
HC.5.2.3 Hearing aids						1,439,660			1,439,660	0.1%

HFxHC	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defence	HF.1.1.1.3 Ministry of Interior Affairs	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.5 Ministry of Education	HF.2.3 Private households' out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HC % of THE
HC.6.1 Maternal and child health; family planning and counselling (subaccount specific)	1,519,633							5,924,140	7,443,773	0.5%
HC.6.1.3 Prevention and immunization for RH	320,124								320,124	0.0%
HC.6.1.99 Other Maternal and child health; family planning and counselling								7,348,378	7,348,378	0.5%
HC.6.2 School health services								1,117,206	1,117,206	0.1%
HC.6.3.99 Other prevention of communicable diseases	7,107,566							39,627,857	46,735,423	3.1%
HC.6.9 All other miscellaneous public health services	469,081							11,697,530	12,166,611	0.8%
HC.7.1.1 General government administration of health (except social security) (subaccount specific)	3,035,940							1,263,027	4,298,968	0.3%
HC.7.1.1.99 Other general government administration of health (except social security)	35,260,751	531,915	1,909,458		168,227		1,188,936	50,161,007	89,220,295	5.9%
HC.nsk Health functions not specified by kind								2,113,657	2,113,657	0.1%
HC.R.1.99 Other Capital formation of health care provider institutions	5,848,519	489,362	2,284,096					9,815,330	18,437,307	1.2%
Column Total (THE)	**162,127,582**	**8,489,362**	**5,990,485**	**971,441**	**180,133**	**1,099,542,464**	**4,817,021**	**218,857,457**	**1,500,975,945**	**100.0%**

HFxHC	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defence	HF.1.1.1.3 Ministry of Interior Affairs	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.5 Ministry of Education	HF.2.3 Private households' out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HC % of THE
HC.R.2 Education and training of health personnel (subaccount specific)	652,087							5,596,366	6,248,452	
HC.R.2.99 Other education and training of health personnel	493,626	63,830		4,796,096				2,963,770	8,317,322	
HC.R.3.99 Other research and development in health	12,184							188,768	200,952	
HC.R.4.99 Other food, hygiene, and drinking water control								437,143	437,143	
Column Total (NHE)	**163,285,479**	**8,553,192**	**5,990,485**	**5,767,537**	**180,133**	**1,099,542,464**	**4,817,021**	**228,043,504**	**1,516,179,814**	
HF % of THE	**10.8%**	**0.6%**	**0.4%**	**0.1%**	**0.0%**	**73.3%**	**0.3%**	**14.6%**	**100.0%**	

ANNEX C. RH SUBACCOUNT MATRICES

TABLE C1. AFGHANISTAN RH SUBACCOUNT—FINANCING SOURCE BY FINANCING AGENT (FSXHF), 2011–2012

FSxHF	FS.1.1.1 Central government revenue	FS.2.2. Household funds	FS.2.3 Non-profit institutions serving individuals	FS.3 Rest of the world funds	Row total	HF % of THE
HF.1.1.1.1 Ministry of Public Health	6,577,377			21,346,547	27,923,925	11.3%
HF. 2.3 Private household's out-of-pocket payment		193,650,212			193,650,212	78.5%
HF.2.4 Non-profit institutions serving households (other than social insurance)			29,255		29,255	0.01%
HF.3 Rest of the world				25,140,947	25,140,947	10.2%
Column Total (THE)	**6,577,377**	**193,650,212**	**29,255**	**46,487,494**	**246,744,339**	**100.0%**
HF.HealthRelated				6,248,452	6,248,452	
Column Total (NHE)	**6,577,377**	**193,650,212**	**29,255**	**52,735,947**	**252,992,791**	
FS % of THE	**2.7%**	**78.5%**	**0.01%**	**18.8%**	**100.0%**	

TABLE C2. AFGHANISTAN RH SUBACCOUNT—FINANCING AGENT BY PROVIDER (HFXHP), 2011–2012

HFxHP	HF.1.1.1.1 Ministry of Public Health	HF. 2.3 Private household's out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HP % of THE
HP.1.1 General hospitals	8,334,383	34,090,724		6,594,262	49,019,370	19.9%
HP.3.4.9 All other outpatient community and other integrated care centers	1,900,296	28,057,301	29,255	11,392,517	41,379,370	16.8%
HP.3.5 Medical and diagnostic laboratories		39,661,897			39,661,897	16.1%
HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods		71,604,260			71,604,260	29.0%
HP.5 Provision and administration of public health programs	1,519,633			5,924,140	7,443,773	3.0%
HP.6.1. Government administration of health	16,169,611			1,230,027	17,399,639	7.1%
HP.7.3 All other industries as secondary producers of health care		20,236,030			20,236,030	8.2%
Column Total (THE)	**27,923,925**	**193,650,212**	**29,255**	**25,140,947**	**246,744,339**	**100.0%**
HP.8.2 Education and training institutions	652,087			5,596,366	6,248,452	
Column Total (NHE)	**28,576,011**	**193,650,212**	**29,255**	**30,737,313**	**252,992,791**	
HF % of THE	**11.3%**	**78.5%**	**0.0%**	**10.2%**	**100.0%**	

TABLE C3. AFGHANISTAN RH SUBACCOUNT—PROVIDER BY HEALTH FUNCTION (HPXHC), 2011–2012

HPxHC	HP.1.1 General hospitals	HP.3.4.9 All other outpatient commun-ity and other integrated care centers	HP.3.5 Medical and diagnostic labora-tories	HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods	HP.5 Provision and administra-tion of public health programs	HP.6.1. Govern-ment administra-tion of health	HP.7.3 All other industries as secondary producers of health care	Row total (THE)	HP.8.2 Education and training institutions	Row total (NHE)	HC % of THE
HC.1.1.1 Inpatient curative care for RH	47,242,711							47,242,711		47,242,711	19.1%
HC.1.3.4 Outpatient curative care for RH	1,776,659	41,379,370				13,133,671		56,289,700		56,289,700	22.8%
HC.4.2 Medical and Diagnostic Imaging			39,661,897					39,661,897		39,661,897	16.1%
HC.4.3 Patient transport and emergency rescue							10,581,143	10,581,143		10,581,143	4.3%
HC.4.9 All other miscellaneous ancillary services							9,654,887	9,654,887		9,654,887	3.9%
HC.5.1.1 Prescribed medicines				71,604,260				71,604,260		71,604,260	29.0%
HC.6.1.1 Maternal and child health, family planning for RH					7,443,773			7,443,773		7,443,773	3.0%
HC.7.1.1.1 General government administration for RH						4,265,968		4,265,968		4,265,968	1.7%
Column Total (THE)	**49,019,371**	**41,379,370**	**39,661,897**	**71,604,260**	**7,443,773**	**17,399,639**	**20,236,030**	**246,744,339**		**246,744,339**	**100.0%**

HC.R.2.1 Education and training for RH									6,248,452	6,248,452
Column Total (NHE)	**49,019,371**	**41,379,370**	**39,661,897**	**71,604,260**	**7,443,773**	**17,399,639**	**20,236,030**	**246,744,339**	**6,248,452**	**252,992,791**
HP % of THE	**19.9%**	**16.8%**	**16.1%**	**29.0%**	**3.0%**	**7.1%**	**8.2%**	**100.0%**		

TABLE C4. AFGHANISTAN RH SUBACCOUNT—FINANCING AGENT BY HEALTH FUNCTION (HFXHC), 2011–2012

HFxHC	HF.1.1.1.1 Ministry of Public Health	HF. 2.3 Private household's out-of-pocket payment	HF.2.4 Non-profit institutions serving households (other than social insurance)	HF.3 Rest of the world	Row total	HC % of THE
HC.1.1.1 Inpatient curative care for RH	7,097,252	34,090,724		6,054,735	47,242,711	19.1%
HC.1.3.4 Outpatient curative care for RH	16,271,099	28,057,301	29,255	11,932,045	56,289,700	22.8%
HC.4.2 Medical and Diagnostic Imaging		39,661,897			39,661,897	16.1%
HC.4.3 Patient transport and emergency rescue		10,581,143			10,581,143	4.3%
HC.4.9 All other miscellaneous ancillary services		9,654,887			9,654,887	3.9%
HC.5.1.1 Prescribed medicines		71,604,260			71,604,260	29.0%
HC.6.1.1 Maternal and child health, family planning for RH	1,519,633			5,924,140	7,443,773	3.0%
HC.7.1.1.1 General government administration for RH	3,035,940			1,230,027	4,265,968	1.7%
Column Total (THE)	**27,923,925**	**193,650,212**	**29,255**	**25,140,947**	**246,744,339**	**100.0%**
HC.R.2.1 Education and Training for RH	652,087			5,596,366	6,248,452	
Column Total (NHE)	**28,576,011**	**193,650,212**	**29,255**	**30,737,313**	**252,992,791**	
HF % of THE	**11.3%**	**78.5%**	**0.01%**	**10.2%**	**100.0%**	

ANNEX D. MAJOR CONTRIBUTORS TO AFGHANISTAN'S HEALTH SECTOR

TABLE D1. CONTRIBUTORS TO AFGHANISTAN'S HEALTH SECTOR, 2008–2009

Financing Source 2011/12	Amount	Percentage
USAID	80,738,829	24.6%
European Union	40,432,983	12.3%
United Nations Agencies	59,077,709	18.0%
UNICEF	37,855,473	64.1%
UNFPA	5,452,502	9.2%
UNODC	923,513	1.6%
WFP	743,324	1.3%
WHO	14,102,897	23.9%
World Bank	32,046,471	9.8%
MSF	17,004,161	5.2%
ICRC	14,307,083	4.4%
ISAF	10,249,062	3.1%
KOICA	7,907,000	2.4%
Multi Donors	6,175,419	1.9%
JICA	5,691,985	1.7%
GAVI/HSS	5,200,091	1.6%
Emergency	5,166,310	1.6%
ARCS	4,817,021	1.5%
CIDA	4,479,015	1.4%
TIKA	3,920,151	1.2%
IFRC	3,222,000	1.0%
Other Donors[1]	27,228,259	8.3%
THE Donors	327,663,549	100.0%
THE Government	89,008,019	-
THE (without household expenditures)	416,671,568	-

[1] This category includes individual contributions under 1% of the total donor health expenditure from Global Fund, AusAID, AKDN, Cordaid, EuropAID, IAM, NZAID, DAC, MSI, NAC, GIZ, SIDA, French Government, CDC, ARD Tetra Tech, AECID, Islamic Relief, ARD/SWSS, Oxfam Novib, SOZO, India Government, Netherland Embassy, French Embassy, LSHTM, Save the Children, Qazaqeshtan Government, Balcombe Trust, Canada Government, FOA, Italian Cooperation, SAF, AHDS, and ADB.

INTERNATIONAL CONTRIBUTORS

- **United States Agency for International Development (USAID)**
  USAID provides support for the delivery of the BPHS and EPHS in 13 provinces through contracting with NGOs; as well as technical assistance in the areas of capacity building, training of health workers, health promotion activities, and increased partnership with the private sector in the area of health care.

  A survey was distributed to both implementing NGOs and the implementing partners to collect expenditure data (costs of service delivery, administration, overheads, etc.).

  USAID also provides pharmaceuticals to NGOs—data on expenditures on pharmaceuticals was also provided by the GCMU. In addition, USAID received a survey similar to other development partners to provide information on its technical assistance projects.

- **European Union (EU)**
  The EU also supports the BPHS and EPHS in 10 provinces through contracting with NGOs. However, financial reports are submitted directly to the EU office in Kabul and not to the MoPH. As a result, the NHA team was only able to collect data from implementing NGOs.[9] The other EU-supported projects' expenditures were obtained through the development partner's survey.

- **The World Bank**
  The World Bank provides support for the delivery of the BPHS and EPHS in 11 provinces through 'contracting-out' with NGOs (through the MoPH) and 'contracting-in' through the MoPH Strengthening Mechanism (MoPH-SM). Additionally, the World Bank supports various other projects in the areas of capacity building, monitoring and evaluation, and disease prevention. BPHS and EPHS data were collected from implementing NGOs, and expenditure data from World Bank support to other development projects were obtained from the MoF expenditure report of the development budget.

- **United Nations (UN)**
  A number of donors contribute substantially to UN-led projects in Afghanistan. UN agencies spend their funds in different ways. In some cases, they coordinate with the MoPH but channel their own funds directly. In other cases, they contract technical assistance to NGOs (often those implementing BPHS and EPHS). WHO, UNICEF, WFP, UNODC, and UNFPA provided their expenditure data by completing the development partners survey.

- **International Security Assistance Force (ISAF)**
  ISAF and Provincial Reconstruction Teams were based in all provinces of Afghanistan in 2011–2012. The majority of ISAF funds are dedicated to construction activities. ISAF

[9] Note: Several NGOs funded by the EU provided expenditure data in Euros. This was converted to USD at an exchange rate of 1 Euro= USD 1.39 (2011–2012) .

provided data on assistance channeled to the health sector for the specific year of the study.

- **Canadian International Development Agency (CIDA)**
  CIDA provided expenditure data for all projects that were recorded as health related. CIDA received a survey similar to other development partners to provide information on its technical assistance projects.[10]

- **Japan International Cooperation Agency (JICA)**
  JICA worked with the NHA steering committee to provide their health expenditure data in a clear and readable format. JICA supports a number of activities promoting urban health, health awareness and education, and reproductive health.[11]

- **Médecins Sans Frontiers (MSF)**
  MSF supports the district hospital in Kabul, provincial hospital in Helmand, and trauma and maternity centers in Kundoz and Khost.

- **International Committee of the Red Cross (ICRC)**
  The ICRC is supporting and running hospitals in Sheberghan and Kandahar as well several orthopedic centers around the country.

- **Korean international Cooperation Agency (KOICA)**
  KOICA is supporting and operating hospitals in Kabul and Parwan and providing capacity building for Parwan Province.

- **Multi Donors**
  There are a number of donors who contribute to the health system of Afghanistan with a small proportion of their contribution already counted under other donors.

- **Global Alliance for Vaccines and Immunization (GAVI)/HSS**
  GAVI support to HSS has been used to boost access to immunization and other health services through in-service training programs for health workers, establishment of health centers, and public information campaigns.

- **Emergency**
  Emergency provides medical and surgical care to victims of war, landmines, and poverty. Emergency also has hospitals in Panjshir, Lashkergah, and Kabul. They also provide health services through first aid posts, health centers, and prison clinics.

- **International Federation of Red Cross and Red Crescent Societies (IFRC)**

[10] Note: Expenditure data was provided in Canadian dollars (CAD). This was converted to USD at an exchange rate of 1 CAD= USD 0.97 USD (2011–2012) .
[11] Note: in some projects, expenditure data were provided in Japanese yen. This was converted to USD at an exchange rate of 1 JYen= 0.013 USD (2011–2012) .

The IFRC is supporting and implementing some of the basic health centers in the country, community-based health interventions, and education and public health programs.

LOCAL CONTRIBUTOR

- **Afghanistan Red Crescent Society (ARCS)**
  The ARCS is an independent Afghan governmental body affiliated with the International Red Cross/Red Crescent movement. The ARCS operates outpatient care centers and hospitals and helps patients with congenital health problems to travel overseas for treatment. ARCS also implements community first aid and other health-related programs. The ARCS obtain funds through various fundraising activities (including lotteries, charity, donor funding, and a customs tax). The ARCS Health Services Director is a member of the NHA Steering Committee. **ARCS is classified as a "non-profit institution serving households."**

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This publication was prepared by the Afghanistan Ministry of Public Health, with support from the Health Policy Project, funded by the United States Agency for International Development (USAID).