

Government of the Islamic Republic of Afghanistan



Ministry of Public Health

NATIONAL HEALTH ACCOUNTS AFGHANISTAN 2008-2009: PRELIMINARY FINDINGS



USAID

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ABBREVIATIONS AND ACRONYMS

ACBAR	Agency Coordinating Body for Afghan Relief
ARCS	Afghan Red Crescent Society
BPHS	Basic Package of Health Services
EPHS	Essential Package of Hospital Services
CAD	Canadian Dollar
CIDA	Canadian International Development Agency
CSO	Central Statistics Organization
EU	European Union
GAVI	The Global Alliance for Vaccines and Immunisation
GCMU	Grants and Contracts Management Unit
GIRoA	Government of the Islamic Republic of Afghanistan
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HH	Household
ICRC	International Committee of the Red Cross
ISAF	International Security Assistance Force
JICA	Japan International Cooperation Agency
MoD	Ministry of Defense
MoE	Ministry of Education
MoEc	Ministry of Economy
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
Mol	Ministry of the Interior
MoPH	Ministry of Public Health
NGO	Nongovernmental Organization
NHA	National Health Accounts
NORAD	Norwegian Agency for Development Cooperation

NRVA	National Risk and Vulnerability Assessment
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket Expenditure
SIDA	Swedish International Development Agency
THE	Total Health Expenditure
TICA	Turkish International Cooperation and Development Agency
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USD	US Dollar
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

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The production of Afghanistan's National Health Accounts (NHA) report for financial year 2008-2009 is the result of a concerted effort from a number of individuals and institutions. Given the complexities of our health sector, collecting the data has been a great challenge for the country. It has taken nearly two years to gather this information, yet the insights that it provides are invaluable. Our intention is to use the NHA data going forward in our policy and planning initiatives.

The NHA estimates are based on data collected by the Ministry of Public Health's (MOPH) Health Economics and Financing Directorate (HEFD), donors, nongovernmental organizations (NGOs), and numerous other government ministries and agencies.

Special thanks to Ahmad Shah Salehi, Director of the Health Economics & Financing Directorate, for overseeing the entire NHA process; and the NHA team consisting of Mohiburrahman Iqbal, Mir Najmuddin Hashimi, and Alim Atarud for their tireless efforts in coordinating data collection, entry, analyses, and compiling the NHA report.

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1. BACKGROUND

Crippled by over two decades of war and suffering from some of the world's poorest health indicators, Afghanistan has ambitiously embarked on its first series of National Health Accounts (NHA) estimations. Motivated by the country's National Strategy on Health Care Financing and Sustainability, NHA information is intended to help mobilize resources and guide investments in Afghanistan's health sector.

Beginning in July 2009, a small team within the Health Economics & Financing Directorate (HEFD) of the Ministry of Public Health (MoPH) was trained to lead and coordinate the NHA study. In order to institutionalize the process—while simultaneously conducting the first exercise—emphasis was placed on maintaining a comprehensive understanding of the NHA methodology, developing mechanisms to ease data collection, and producing a long-term work plan.

NHA is an internationally recognized framework for measuring the total volume of expenditure and tracking the flow of funds in a country's health system. The standard set of NHA tables provides comparable and comprehensive country-level information on the generation, allocation, and utilization of health system resources. It charts the flow of actual expenditures on health from different financing sources (e.g. donors, Ministry of Finance) to those who determine how the funds are utilized (e.g. Ministry of Public Health, NGOs [NGOs]). Furthermore, NHA disaggregates expenditure by end use, providers who delivered the service, and population sub-groups who benefited.

For ease of comparability with other peers and neighbors and over time, countries are encouraged to follow the standard NHA methodology. However, there is some flexibility in disaggregating by certain health functions and including country-specific providers or programs.

This report describes findings from the first round of NHA in Afghanistan, which was undertaken in 2009-2010 for financial year 2008-2009 (April 1, 2008 – March 31, 2009), and implemented by the MoPH with technical support from USAID's Health Systems 20/20 project. The findings will be used as a platform for informing policy decisions concerning health sector resource allocation.

1.1 THE NHA CONCEPT AND APPLICATION

NHA answers essential questions including who pays for health care, how much, and for what services. This allows national decision-makers to prioritize funds and design policies that promote a more sustainable, equitable, and efficient allocation of resources. NHA is more than a resource-tracking tool—for example, it can provide the necessary evidence base to implement policies aimed at easing the household financial burden on health; and guide governments in adjusting their own investments in the health sector in response to inflows of external assistance. Knowledge on the distribution of resources across the health system can assist countries in benchmarking their performance against established targets and goals; and measure whether specific financial interventions are having the desired health impacts. In the process, NHA promotes transparency and accountability in the health system, documents resource gaps, and can help advocate for additional resources in the health sector.

1.2 POLICY OBJECTIVES OF THE FIRST ROUND OF NHA IN AFGHANISTAN

With approximately 500,000 people added to its population each year, the need for better health care in Afghanistan has never been more pressing.¹ The overall goal of the NHA study was to estimate total health expenditures (THE) in 2008-2009 in order to direct policy formulation and development. More specific objectives, in line with Afghanistan's National Strategy on Health Care Financing and Sustainability include:

- Monitoring current health expenditures trends in order to project future financing needs
- Determining the distribution of THE by financing sources and the institutions that manage the funds; and by provider of health services and functions (i.e. the services that are purchased)
- Motivating change in the public health budgeting process at both the central and provincial levels; and identifying underfunded health sectors
- Evaluating donor financing relative to domestic financing and its implications for the long-term sustainability of Afghanistan's health sector
- Establishing a process for institutionalizing the NHA methodology

1.3 ORGANIZATION OF THIS REPORT

This report is organized into four sections. Section 1 has provided background information on NHA in general and NHA development in Afghanistan. Section 2 describes the methodology used for this NHA. Section 3 presents general NHA findings. Section 4 provides policy implications of this data. Section 5 discusses the institutionalization of NHA in Afghanistan.

¹ CSO (2008). *Afghanistan Statistical Yearbook 2007-08*. Kabul, Central Statistics Organization.

2. METHODOLOGY

2.1 OVERVIEW OF APPROACH

The 2008-2009 Afghanistan NHA was conducted in accordance with the *Guide to Producing National Health Accounts, with Special Application for Low-income and Middle-income Countries* (World Health Organization [WHO], World Bank, and USAID 2003) and used both primary and secondary data.

A wide range of data and information were collected from various government documents and key informants. The following primary data sources were used:

- Donor surveys (bilateral, multilateral donors, and the International Security Assistance Force [ISAF])
- NGOs surveys (those responsible for delivering health care services)
- Ministry surveys (fund recipients)

The following secondary data sources were used:

- Afghanistan National Budget 1387
- Development Assistance Database (DAD) (Unaudited), Ministry of Finance

In addition, several general questions on out-of-pocket (OOP) expenditures were added to the Afghanistan Mortality Survey.

It is important to note that some of the expenditures at the provider and functional level could not be disaggregated. This was due to a lack of 1) disaggregated detail in the household survey that was used, 2) robust costing data at both the hospital and health clinic levels, and 3) provider-level expenditure data. To minimize the number of assumptions, most expenditure figures have been kept at an aggregated level.

2.2 DATA COLLECTION

2.2.1 DONOR SURVEYS

Development assistance constitutes a large share of financing for the health sector in Afghanistan. The Ministry of Finance (MoF) provided a list of all donors (including bilaterals, multilaterals, UN agencies) providing support to health sector activities. Seventeen donors were identified and surveyed; ten returned a completed survey questionnaire. The donor surveys were designed to overlap with the NGO surveys and government fiscal reports. Where possible, the funds were tracked from the donor to the NGO implementing partner or the MoPH and the expenditure numbers from these latter sources were used. In cases where donors did not respond to the survey, data from the Development Assistance Database (DAD) of the Ministry of Finance (MoF) were used.

2.2.2 NGO SURVEYS

NGOs play a significant role in Afghanistan's health sector. The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) are the primary means of delivering primary and secondary health care services in Afghanistan. Under the leadership and stewardship of the Ministry of Public Health, the BPHS and EPHS are currently funded by three of the country's largest donors: the European Union (EU), United States Agency for International Development (USAID), and the World Bank. Currently, the BPHS and EPHS

services are contracted out to national and international NGOs and the Strengthening Mechanism of MoPH. Please refer to Section 3.4.1 for further discussion.

The AID Management Unit of the MoPH provided a list of all *BPHS/EPHS implementing NGOs*. Twenty-two were identified and surveyed; 16 returned a completed survey questionnaire. For those NGOs that did not return a completed survey, the AID Management Unit provided the data.

To understand the provision of services outside of the BPHS and EPHS, the Agency Coordinating Body for Afghan Relief (ACBAR) and International Relations Department of MoPH provided a list of *all health sector NGOs*. The Ministry of Economy (MoEc) also has a database for NGOs. However, as some of the information from the MoEc database was duplicative or inconsistent with data provided by donors and NGOs themselves, it was not considered for the purposes of this exercise.

Please refer to Annex 3 for more information on specific donors and recipients of funding.

2.2.3 MINISTRY SURVEYS

Outside of the MoPH, there are a number of other ministries which 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), and Ministry of Higher Education (MoHE). The MoD and MoI run hospitals and clinics nationwide (though MoD centers cater specifically to soldiers and their families); while the MoHE operates a number of medical faculties and teaching hospitals in select provinces. A survey was circulated to each of these ministries. All five responded to this survey.

3. GENERAL NHA FINDINGS

3.1 INTRODUCTION

Though THE in Afghanistan has increased over the last five years, the general health status of the population remains dire. The total life expectancy in Afghanistan in 2008 was 44 years, roughly 10 years below the average of Sub-Saharan Africa.^{2,3} Other health indicators do not fare much better. Maternal mortality, estimated at 1,400/100,000 live births per year (with only 24 percent of births attended by skilled birth attendants) is the highest in the world; and infant and under-five mortality rates estimated at 111 and 161 per 1000 births per year, respectively, are up to four times higher than in neighboring countries.^{4,5} In addition, over one-third of child deaths are due to undernutrition; with stunting prevalence in Afghanistan the highest in the world.⁶ Yet, NHA findings indicate that outside of primary care services provided within the BPHS, only two percent of THE is devoted to maternal and child health interventions.

Similarly, NHA estimates reveal that a mere three percent of investments (outside of the BPHS) are being directed to the prevention of malaria and tuberculosis, the main communicable diseases afflicting the population. Both of these diseases can be prevented and treated at fairly low cost. Resources are also being allocated to the prevention of HIV/AIDs (which is emerging as an epidemic largely due to the growing number of drug users) with children particularly susceptible to the disease.⁷

Minimal data exists on the current health status of the population and resource allocations in the health sector. NHA estimates serve to provide insight on the latter by measuring THE as they flow through the country's health system. As this is Afghanistan's first NHA exercise, no previous data is available for comparison purposes. All figures are presented in nominal US 2008-2009 dollars (where US\$1 = 50 Afs). The purpose of this information is to inform decision making and guide general budgeting and planning processes within the health sector.

Please refer to Annex 1 for a detailed explanation of the main NHA classifications used throughout this report.

² CSO (2008).

³ UNICEF (2009), *The State of the World's Children 2009 – Maternal and Newborn Health*. UNICEF.

⁴ WHO, UNICEF, UNFPA and the World Bank (2010). *Trends in Maternal Mortality*.

⁵ UNICEF (2009).

⁶ UNICEF (2009).

⁷ UNODC. (2010). *Reducing Drug Demand and HIV in Afghanistan*. UNODC.

3.2 SUMMARY OF GENERAL NHA FINDINGS

In 2008-2009, THE in Afghanistan was US \$1,043,820,810, almost ten percent of the country's gross domestic product (GDP). This represented a per capita expenditure of almost US\$42. The share of domestic revenue allocated to health was only four percent.⁸ While this figure is comparable to Afghanistan's neighbors and income peers (Figure 3.1), it is significantly lower than the 15 percent recommended by the Abuja Declaration.⁹ Of THE, government sources of funding accounted for six percent; donor sources 18 percent; and private sources¹⁰ 76 percent. Out-of-pocket (OOP) spending on health was US\$31 per person.

Outpatient care centers were the main providers of health care, representing 32 percent of THE, followed by hospitals, representing of 29 percent of THE.¹¹ Of health care functions, the majority of expenditures, 59 percent, were directed toward curative care. Spending on this area can be largely attributed to the provision of the Government of the Islamic Republic of Afghanistan's (GIROA) BPHS and EPHS, both of which have been successful in delivering priority health services to a majority of the population.

TABLE 3.1: SUMMARY OF GENERAL NHA FINDINGS, 2008-2009

Indicators	2008-2009
Total population	25,011,400
Total real GDP	US \$10,843,340,000
Per capita income	US \$426
Average exchange rate (US\$: Afs)	1:50
Total government health expenditure	US \$63,892,239
Total health expenditure (THE)	US \$1,043,820,810
THE per capita	US \$42
THE as % of nominal GDP	9.6
Government health expenditure as % total government expenditure	4.0
Financing Source as a % of THE	
Public	6
Private	76
Donor	18
Household (HH) Spending	
Total HH (OOP) spending as % of THE	75
Total HH (OOP) spending per capita	US \$31
Financing Agent Distribution as a % of THE	
Public	11
Household	75
Non-governmental organizations	5
Rest of the World	8
Provider Distribution as a % of THE	
Hospitals	29
Outpatient care centers	32
Retail sale and other providers of medical goods	28
Other	11
Function Distribution as a % of THE	
Curative care	59
Pharmaceuticals	28
Prevention and public health programs	5
Health administration	5
Capital formation	2
Other	1

Sources: Central Statistics Organization (CSO) for population, GDP, and per capita income estimates

Note: World Bank estimates place population and real GDP estimates at 29,021,099 and US\$11,404,683,367, respectively

Due to rounding, percentages throughout this report may not always total 100%

⁸ This percentage is equal to total domestic revenues dedicated to health divided by the sum of the total operating budget and discretionary budget of the development budget. Please refer to Section 3.3.1 for more details.

⁹ The Abuja Declaration emerged as the result of a summit in Abuja, Nigeria where sub-Saharan African countries pledged to allocate at least 15 percent of their national budgets to health. For more information, please refer to The Abuja Declaration. African Summit on Roll Back Malaria, Abuja, Nigeria. April 2001. < http://www.rollbackmalaria.org/docs/abuja_declaration.pdf>

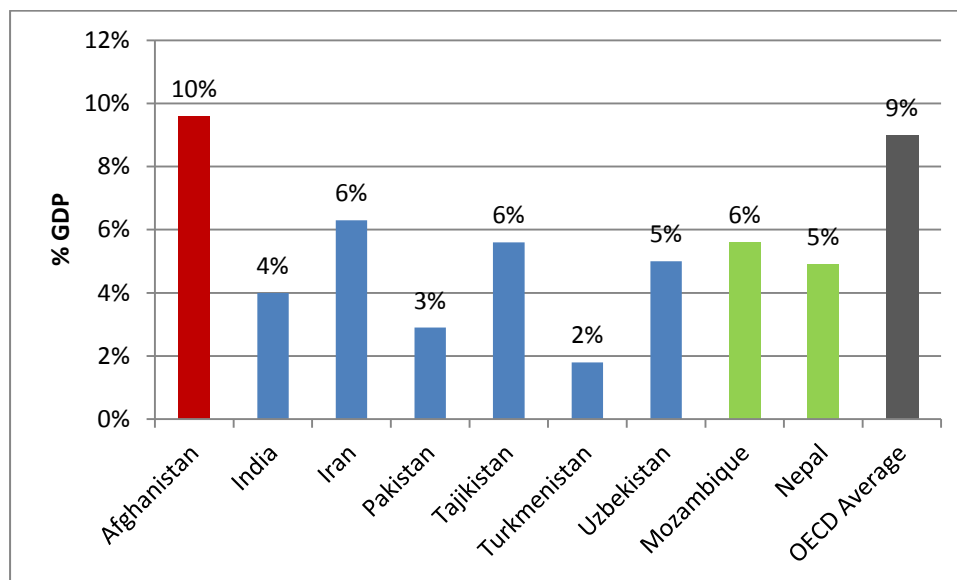
¹⁰ Private expenditures include funds from households, non-profit institutions serving households, and private enterprises. In Afghanistan's case, 99.7 percent of private expenditures are from households.

¹¹ Outpatient care centers include: mobile clinics, health posts, sub-health centers, basic health centers, and comprehensive health centers /polyclinics. Please refer to Annex 1 for more information.

3.2.1 INTERNATIONAL COMPARISONS

Afghanistan dedicates ten percent of its GDP to health care. As shown in Figure 1, this share is higher than that of its neighbors, income peers (Mozambique and Nepal with per capita incomes of US\$438 and US\$440, respectively), and OECD countries.

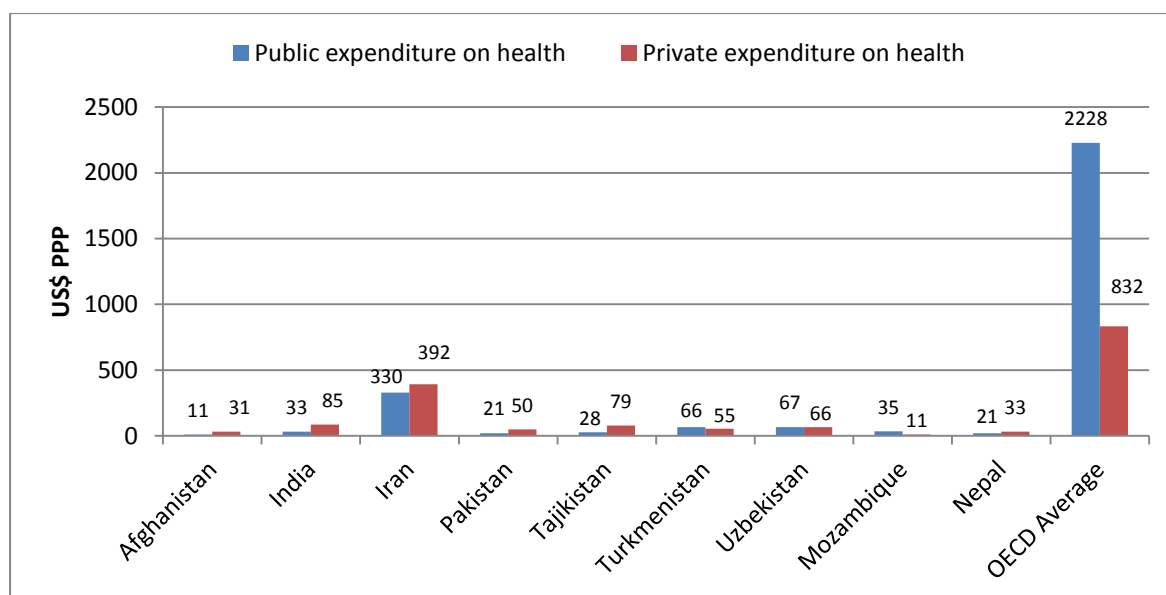
FIGURE 3.1: HEALTH EXPENDITURE AS A SHARE OF GDP: AFGHANISTAN, ITS NEIGHBORS, INCOME PEERS, AND OECD COUNTRIES, 2008



Source: WHO, OECD

At the same time, Figure 3.2 reveals that Afghanistan's total per capita expenditure on health care, \$US42 is far lower than that of its neighbors.

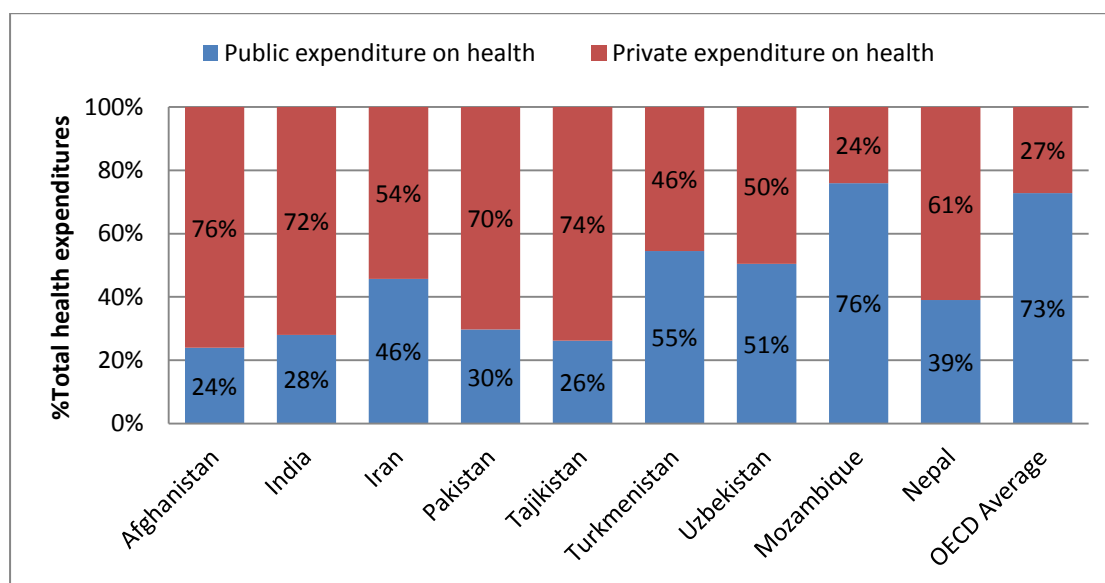
FIGURE 3.2: HEALTH EXPENDITURE PER CAPITA, PRIVATE AND PUBLIC EXPENDITURE: AFGHANISTAN, ITS NEIGHBORS, INCOME PEERS, AND OECD COUNTRIES, 2008 (US\$ PPP)



Source: WHO, OECD

But while the country's per capita spending is on par with its *income peers*, Figure 3.3 further reveals that private expenditures as a share of THE in Afghanistan is unparalleled (worldwide, only Myanmar, Guinea, and the Lao People's Democratic Republic are higher at 89 percent, 89 percent, and 82 percent, respectively).¹² NHA findings estimate that household OOP constitute 99.7 percent of private expenditures.

FIGURE 3.3: HEALTH EXPENDITURE PER CAPITA, PRIVATE AND PUBLIC EXPENDITURE: AFGHANISTAN, ITS NEIGHBORS, INCOME PEERS, AND OECD COUNTRIES, 2008 (%)



Source: WHO, OECD

Forty-two percent or approximately 10.5 million individuals in Afghanistan live below the national poverty line (less than US\$1/day). With per capita health expenditures estimated at US \$31, this type of spending is disconcerting and unsustainable.¹³ Such high household OOP highlight the need to develop mechanisms to reduce the financial burden on the households, such as increased government allocations to the health sector and the introduction of financial risk protection mechanisms.

¹² Private expenditures include funds from households, non-profit institutions serving households, and private enterprise. In Afghanistan's case, 99.7 percent of private expenditures are from households.

¹³ Poverty threshold for Afghanistan provided by the U.S. Government Accountability Office.

3.3 FINANCING SOURCES: WHO PROVIDES THE FUNDING FOR HEALTH CARE?

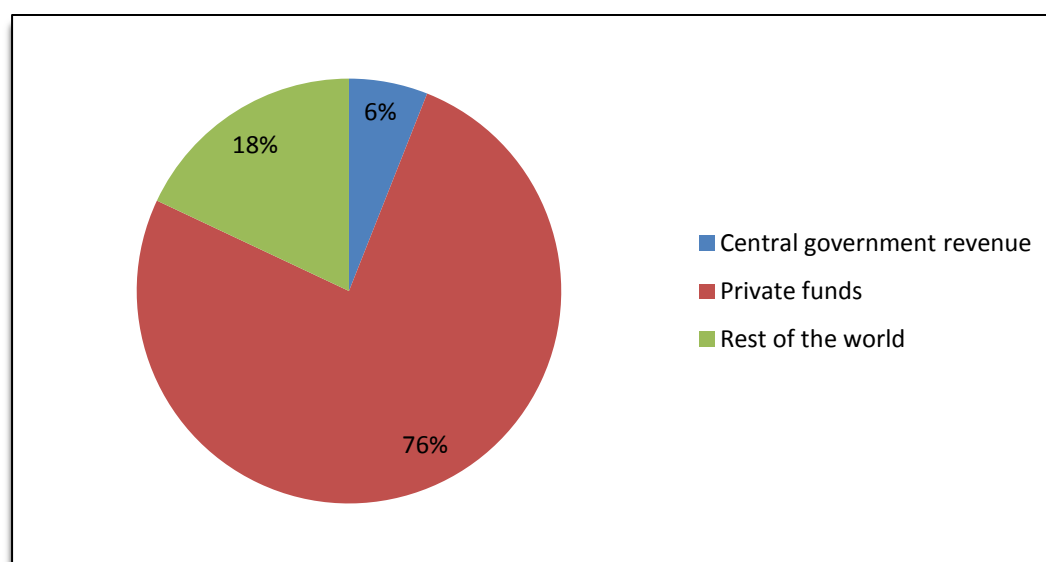
In the NHA framework, financing sources are defined as those entities or institutions that provide the funds used in the health care system. It is the *source* of funds. The health sector in Afghanistan obtains varying levels of funding from traditional sources, namely public (central government), private, and donors. Table 3.2 and Figure 3.4 provide a breakdown of THE by financing source.

THE in Afghanistan was just over US\$1.0 billion, which translates to US\$42 per capita. While this is actually higher than the US\$34 that the WHO recommends for the cost of an essential basic package of health care services¹⁴, the reality is that the source of this financing disproportionately falls on the shoulders of households. Private expenditures on health constitute roughly 76 percent of THE expenditures, of which household OOP is approximately 99.7 percent. This is followed by the “rest of the world” (donors) at 18 percent, with the central government’s contribution being the least at six percent.

TABLE 3.2: BREAKDOWN OF EXPENDITURE BY FINANCING SOURCE, 2008-2009

Sources	Amount (US \$)	Percentage
Public	63,892,239	6.1
Private		
<i>Household funds</i>	787,076,258	75.4
<i>Non-profit organizations serving households</i>	2,141,457	0.2
Rest of the world	190,710,857	18.3
Total	1,043,820,810	100.0

FIGURE 3.4: BREAKDOWN OF EXPENDITURES BY FINANCING SOURCE, 2008-2009



¹⁴ WHO. (2001). Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva, WHO.

3.3.1 HEALTH SPENDING WITHIN THE NATIONAL BUDGET

Table 3.3 shows the distribution of health expenditures across the two main components of Afghanistan's national budget: core budget (operating and development) and external budget.

TABLE 3.3: BREAKDOWN OF PUBLIC EXPENDITURES ON HEALTH, 2008-2009

Indicators	Total Expenditures	Total Health Expenditures		
		Domestic Revenue	Donor Contribution	Percentage of total expenditures
External budget	4,859,150,000	--	143,578,199	3.0
Core budget				
<i>Operating</i>	1,307,190,000	45,303,950	--	3.5
<i>Development (Discretionary budget)</i>	308,100,000	18,588,288		6.0
<i>Development (Non-discretionary budget)</i>	1,080,059,800		47,132,658	0.6
Total Expenditures	7,554,499,800	63,892,239	190,710,857	3.4

Source: Afghanistan National Budget 1387

Donor contributions represent 75 percent of total public expenditures on health, suggesting that health care priorities are largely donor driven.¹⁵ Donors contribute to health activities via the *development budget* of the country's core budget (funds are earmarked by donors and not subject to discretionary allowance by the government); and the *external budget*, where funds are disbursed directly by donors. In 2008-2009, support for the BPHS and EPHS was channeled entirely through the external budget through the EU and USAID.¹⁶ The World Bank channeled its support for the BPHS, EPHS, and technical assistance through the development budget. In 2008, almost 25 percent of all donor funds for health flowed through the development budget, while the remainder was channeled through the external budget.

Government contributions are mainly channeled through the other component of the core budget, the *operating budget*. The operating budget consists mainly of staff wages, salaries, and other recurrent expenditures (including the purchase of medical goods for public hospitals) and is financed almost entirely by GIRoA. Less than one-third of government contributions flow through the discretionary portion of the development budget. The alarmingly low government contribution to health (only four percent of total domestic revenues), compared to other sources, is disconcerting and raises significant questions about the long-term sustainability of the health sector.

3.3.2 HOUSEHOLD EXPENDITURES ON HEALTH

Households provide the largest source of funds for health care in Afghanistan, approximately 75 percent of THE. For the purposes of this exercise, only direct costs used to access healthcare services are included in this figure (food, accommodation, and transportation costs are excluded). The figure presented is consistent with mid-line estimates in the past (outside of this NHA exercise) which have placed out-of-pocket expenditures at roughly 74-79 percent of THE.¹⁷

3.3.3 OTHER PRIVATE EXPENDITURES ON HEALTH

Several privately owned firms are believed to offer health benefits as a part of their compensation package for employees. However, as both the public and private insurance sectors are very underdeveloped in Afghanistan, a decision was made to not track expenditures associated with the insurance sector during this round of NHA.

¹⁵ Total public expenditures are equal to the sum of the government's core budget and external assistance. In Table 3.1., this is represented by the sum of public and rest of the world funds.

¹⁶ As of 2010, USAID has channeled its support through the development budget

¹⁷ World Bank. (2009). *Building on Early Gains on Afghanistan's Health, Nutrition, and Population Sector*. Washington, D.C., World Bank.

3.4 FINANCING AGENTS: WHO CHANNELS HEALTH FUNDS?

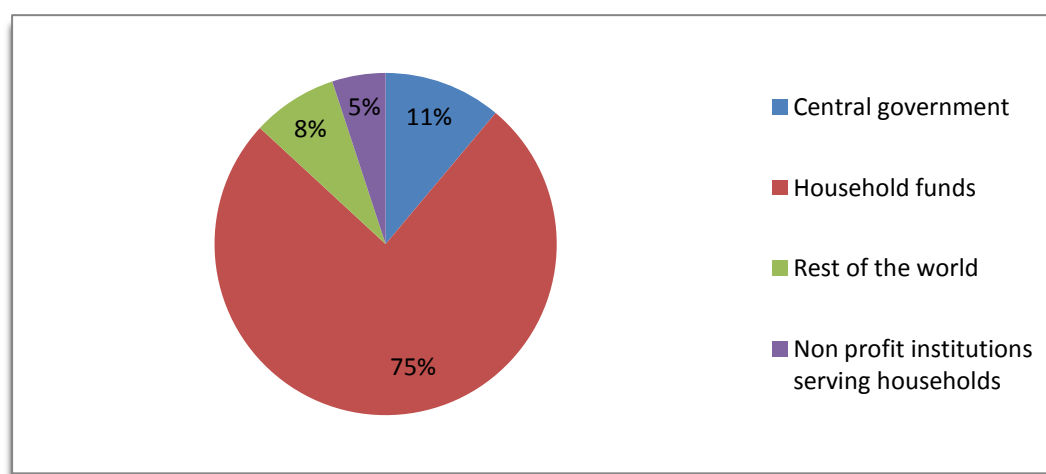
Financing agents are institutions that receive funds from financing sources to pay for and purchase health goods and services. Financing agents in the process of channeling funds, maintain control over how resources will be allocated and to which specific services. Financing agents in Afghanistan consist of the central government (primarily the MoPH), households, NGOs, and donors through the external budgetary support (as discussed above).

As shown in Table 3.4 and Figure 3.5, the largest financial agent in Afghanistan are households which manage 75 percent of health funds (that is, all the funds they spend). Households are followed by the central government and donors managing 11 percent and eight percent of funds, respectively. Non-profit institutions serving households manage approximately five percent of health funds in Afghanistan.

TABLE 3.4: BREAKDOWN OF EXPENDITURE BY FINANCING AGENT, 2008-2009

Agents	Amount (US \$)	Percentage
Public		
<i>Ministry of Public Health</i>	103,486,835	10.0
<i>Ministry of Defense</i>	5,690,434	0.5
<i>Ministry of the Interior</i>	1,006,724	0.1
<i>Ministry of Higher Education</i>	5,363,761	0.5
<i>Ministry of Education</i>	17,760	<0.1
Household funds	787,076,258	75.4
Non-profit organizations serving households	51,064,454	4.9
Private firms and corporations	2,419,970	0.2
Rest of the world	87,694,612	8.4
Total	1,043,820,810	100.0

FIGURE 3.5: BREAKDOWN OF EXPENDITURES BY FINANCING AGENT. 2008-2009



3.4.1 WHO MANAGES THE BPHS?

Approximately one-third of all donor funds are dedicated to the BPHS. NGOs are contracted to provide these services, but the manner by which this is done varies by donor. Whereas the EU handles all contracts through its local office in Kabul and transfers funds to NGOs directly, in 2008-2009 the World Bank and USAID managed their contracts through the HEFD of the MoPH.

The World Bank channels its funds to NGOs through the MoPH; while USAID prior to 2010, channeled its funds to NGOs through the World Health Organization (WHO).¹⁸ In addition, the Global Alliance for Vaccines and Immunisations (GAVI) also provides assistance to the BPHS via mobile clinics. Similar to the World Bank, GAVI funds are transferred to NGOs through the MoPH. The stewardship of MoPH ensures that providers of BPHS deliver services responsibly, meet minimum compliance standards, and are held accountable for the populations and geographies they serve. Table 3.5 summarizes this information.

TABLE 3.5: DONOR CONTRACTING OF BPHS, 2008-2009

Donor	Flow of funds	Total BPHS support (US \$)	Financing Agent	Contracts Management
EU	EU → NGOs	24,981,628	NGO	EU
World Bank	World Bank → MoPH ^{1/}	20,273,988 ^{2/}	MoPH	HEFD
USAID	USAID → WHO → NGOs ^{3/}	32,955,446	Rest of the World	HEFD
GAVI	GAVI → MoPH → NGOs	3,202,715	MoPH	HEFD

^{1/}All World Bank funds are directed through MoF which then channels resources to MoPH

^{2/} Of this total, US \$ 18,143,377 represents contracting with NGOs; US \$ 2,187,208 represents contracting with MoPH-SM

^{3/} As of 2010, USAID has channeled BPHS funds directly through the MoPH

The World Bank also provides funding toward the MoPH-Strengthening Mechanism (MoPH-SM) which delivers the BPHS and EPHS in three provinces: Kapisa, Panjshir, and Parwan. Under the MoPH-SM, financial resources are channeled through provincial governments and services are contracted to MoPH staff (in lieu of NGOs).

¹⁸ As of 2010, USAID has channeled BPHS funds directly through the MoPH

3.5 PROVIDERS OF HEALTH CARE: WHERE ARE HEALTH FUNDS BEING USED?

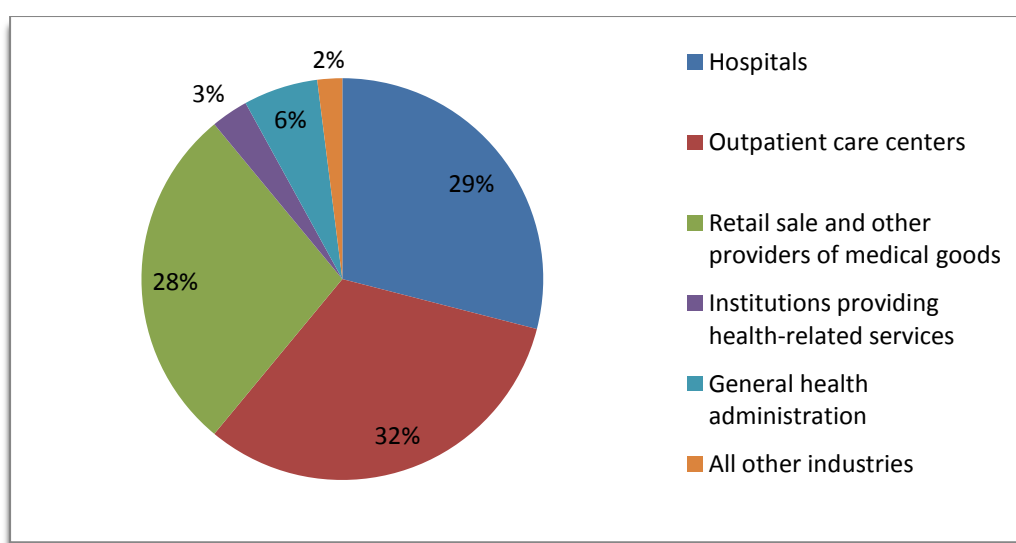
Health care providers are entities that receive money to produce goods and services within the health accounts boundary: these include hospitals and outpatient care centers, pharmacies and shops, as well as general health administration. General health administration includes the MoPH, provisional health offices, and other ministries who receive funds for administrative purposes (i.e. wages, overhead, development of information systems, training activities).

In 2008-2009, the largest share of THE went to outpatient care centers (32 percent), followed by hospitals (29 percent), thanks largely to nationwide provision of the BPHS and EPHS. Overall, more funds were allocated to public facilities (33 percent) than to private health facilities (28 percent). While 71 percent of total funds to public facilities came from households; all funds to private facilities came from households.

TABLE 3.6: BREAKDOWN OF EXPENDITURES BY PROVIDER, 2008-2009

Providers	Amount (US \$)	Percentage
Hospitals	306,161,881	
<i>Public</i>	232,984,130	22.3
<i>Private</i>	73,177,751	7.0
Outpatient care centers	330,862,683	
<i>Public</i>	114,219,260	10.9
<i>Private</i>	216,643,423	20.8
Retail sale and other providers of medical goods	294,902,083	28.3
Provision and administration of public health programs	8,355,822	0.8
General administration	58,694,885	5.6
Institutions providing health-related services	7,269,577	3.6
All other industries	37,573,878	0.7
Total	1,043,820,810	100.0

FIGURE 3.6: BREAKDOWN OF EXPENDITURE BY PROVIDER, 2008-2009



3.5.1 WHICH PROVIDERS CONSUME HOUSEHOLD OOP FUNDS?

In 2008-2009, the majority of inpatient visits took place at public hospitals while the majority of outpatient visits took place at private facilities. Seventy-four percent of household health spending was at private health care providers including hospitals and clinics, doctors, and pharmacies. Government-owned hospitals and health centers consumed 24 percent. The remaining two percent was used to obtain care at mosques, refugee camps, and charitable foundations.

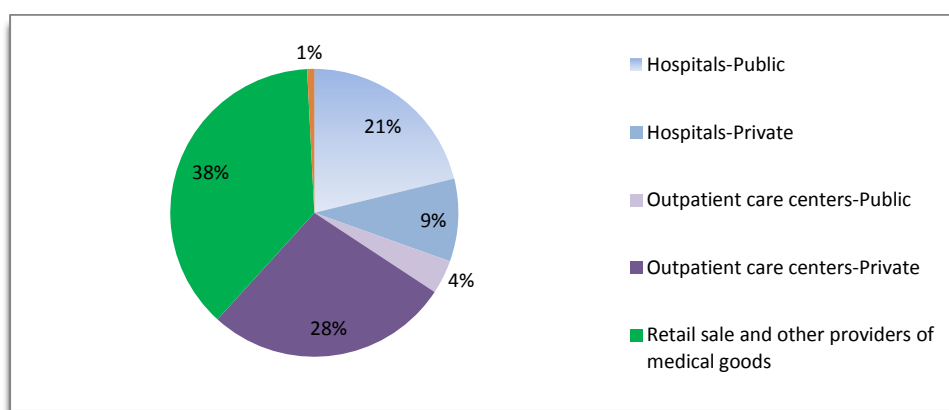
It is likely that because of high expenses related to inpatient care, this type of care is most often sought at public facilities where services are advertised as free. However, Table 3.7 shows that 69 percent of total hospital care expenditures are actually incurred at public hospitals while 88 percent of total outpatient-based care expenditures are incurred at private health centers. It also reveals that expenditures at hospitals and outpatient care centers are fairly similar, each constituting nearly one-third of total household health expenditures.

When considering these figures, it is important to again note that, throughout this report, household OOP expenditure includes only direct health costs incurred by a household while accessing health care. Associated non-health costs such as transportation, lodging, and dining are not included.

TABLE 3.7: BREAKDOWN OF HH OOP EXPENDITURES BY PROVIDER, 2008-2009

Provider	Amount (US \$)	Percentage
Hospitals	239,675,625	
<i>Public</i>	166,497,873	21.2
<i>Private</i>	73,177,751	9.3
Outpatient care centers	246,414,475	
<i>Public</i>	29,771,053	3.8
<i>Private</i>	216,643,423	27.5
Retail sale and other providers of medical goods	294,884,323	37.5
All other industries	6,101,835	0.8
Total	787,076,258	100.0

FIGURE 3.7: BREAKDOWN OF HH OOP EXPENDITURES BY PROVIDER, 2008-2009



Spending at outpatient care centers may seem considerable given the availability of the BPHS. However, BPHS facilities are not always easily accessible and in areas where they are, quality of services is perceived to be poor with long waiting times. Individuals may be forced to seek treatment at BPHS facilities either “after hours” (at higher cost) or as NHA findings seem to indicate, private facilities, which are traditionally more expensive. There is little difference in trends between urban and rural households when seeking outpatient care. Rural and urban households directed 68 percent and 71 percent of their total health expenditures, respectively, to private facilities.

FIGURE 3.8: BREAKDOWN OF HH OOP EXPENDITURES BY PUBLIC AND PRIVATE FACILITIES (OUTPATIENT CARE CENTERS), 2008-2009

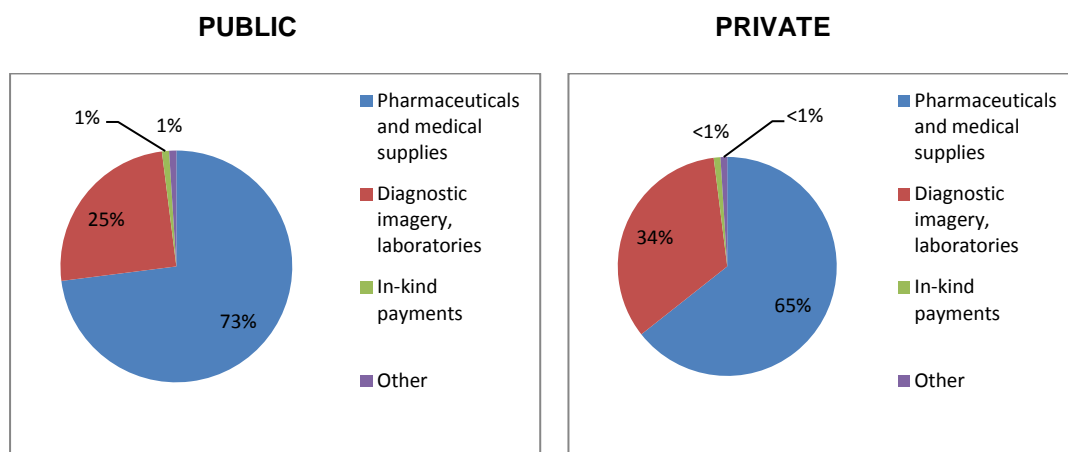
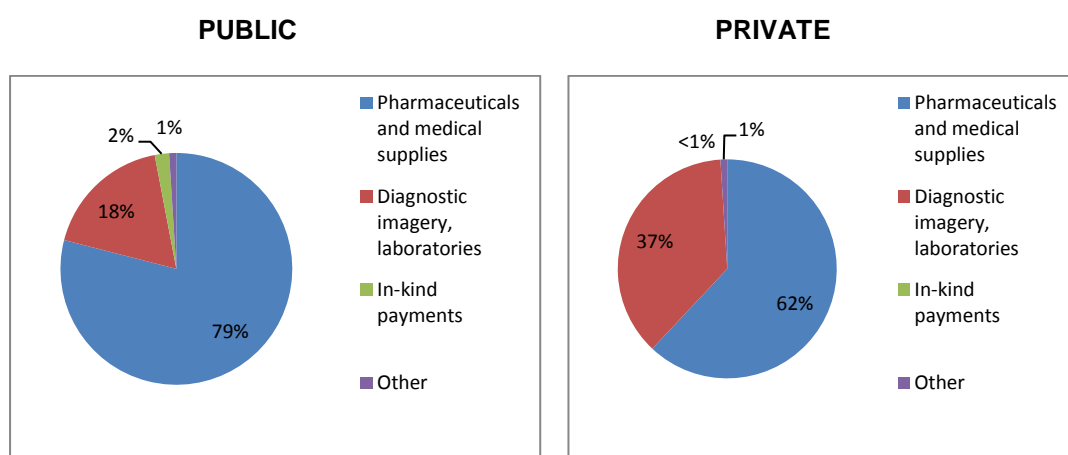


FIGURE 3.9: BREAKDOWN OF HH OOP EXPENDITURES BY PUBLIC AND PRIVATE FACILITIES (HOSPITALS), 2008-2009



Relative to spending on public outpatient care centers (which is only 12 percent of total spending on outpatient care), spending on public hospitals is substantial. Sixty-nine percent of total spending on hospitals takes place at public hospitals. This is particularly surprising as the EPHS mandates a certain level of basic services to be offered at all its hospitals. Interestingly, over 75 percent of direct hospital treatment costs at public hospitals are reported as pharmaceutical purchases. Ancillary costs (such as laboratories and x-rays) and in-kind payments comprise the bulk of the remainder.

The reasons for such high OOP costs are twofold. For one, hospitals often do not maintain adequate supplies of necessary equipment for treatment and surgeries (essential medicines, local anesthetics, and surgical instruments) and as a result purchase these from outside facilities at higher cost. These costs are then borne by the patient during the point-of-service. Secondly, there is a tendency to prescribe services that are not always needed, particularly medications. Medication side effects from improper diagnosis combined with minimal understanding of drug interactions can lead to conditions worsening and elevated costs. Information asymmetry leaves patients with little knowledge and awareness on the options available to them such that decision-making authority on the final course of treatment is left to physicians.

Given the intent and purpose of the BPHS and EPHS to reduce patient costs and expand access to treatment, the policy implications of this are substantial.

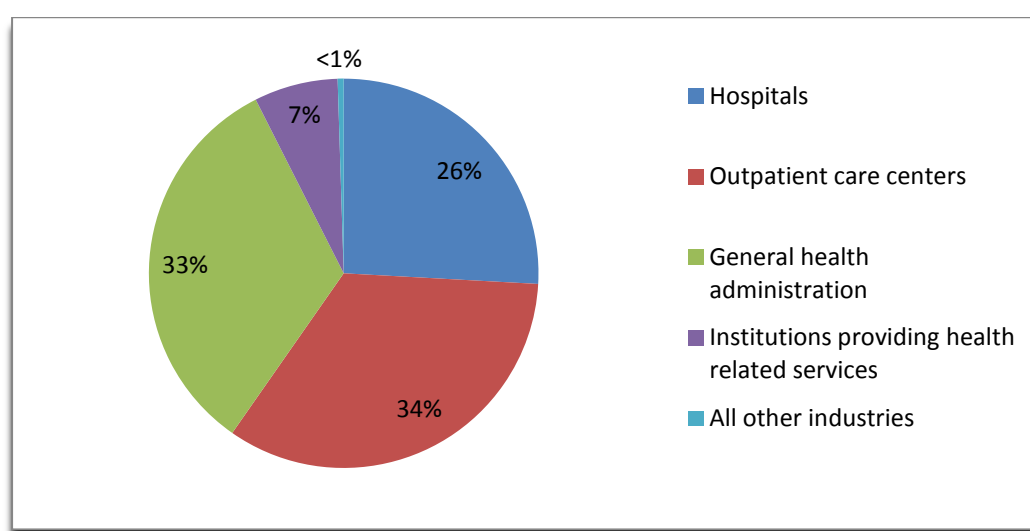
3.5.2 WHICH PROVIDERS CONSUME MoPH FUNDS?

Of the funds managed by the MoPH, government-owned hospitals and outpatient care centers consumed the largest proportion, at 60 percent, again largely because of its role in managing and coordinating the BPHS and EPHS. Roughly one-third, or 33 percent of MoPH managed funds were allocated toward general health administration.

TABLE 3.8: BREAKDOWN OF MoPH EXPENDITURES BY PROVIDER, 2008-2009

Provider	Amount (US \$)	Percentage
Hospitals	27,010,907	26.1
Outpatient care centers	34,775,094	33.6
General health administration	33,649,185	32.5
Institutions providing health-related services	7,584,148	7.3
All other industries	467,501	0.5
Total	103,486,835	100.0

FIGURE 3.10: BREAKDOWN OF MoPH EXPENDITURES BY PROVIDER, 2008-2009



General administration refers only to administration occurring at the central level and provincial levels and not administration at facilities (which is captured under hospitals and outpatient care centers). Over 40 percent of the funds allocated to this area were directed toward capacity building activities for the MoPH. This includes technical assistance in the areas of grant management (particularly as it relates to NGO contracting), information systems, and policy development, and also includes training and other professional development activities for staff designed to enhance knowledge and capabilities within the MoPH.

Eight percent of allocations under general administration were directed toward administration of the MoPH-SM) which delivers the BPHS and EPHS in three provinces.

The seven percent of funds received by institutions providing health-related services were used mainly for vaccination campaigns and related disease prevention activities.

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

Health care functions refer to the goods and services that are provided within the health accounts boundary: these generally include curative care (inpatient and outpatient)¹⁹; preventive care and other activities promoting healthy living and awareness (often through public campaigns and community-based activities); consumer purchases of pharmaceuticals and other medical non-durables; training of health workers and other personnel; investments in infrastructure; and health administration.

It is important to note the distinction between the MoPH definition of “prevention” and the NHA classification of “prevention and public health.” The MoPH considers prevention services to be those which prevent illness and disease. The NHA definition of prevention under the classification “HC.6 Prevention and public health” is composed of “programmatic” expenditures, on prevention and public health—such as vaccination campaigns and health awareness and promotion activities—and does not include preventive services delivered as part of outpatient care.

In line with this, the seven main elements targeted by the BPHS (*within* the care that it delivers): Maternal and Newborn Care, Child Health and Immunization, Public Nutrition, Communicable Disease Treatment and Control, Mental Health, Disability and Physical, Rehabilitation Services, Regular Supply of Essential Drugs, are considered to be priority areas *that are addressed in the provision of outpatient care*. **Therefore, all the BPHS and EPHS activities are captured under curative care.** On the other hand, programmatic expenditures in the aforementioned areas are accounted for under their individual classifications.

In Afghanistan, the most significant area of spending was in curative care (59 percent) followed by consumer purchases of pharmaceuticals and other medical non-durables (28 percent). Investments in capital formation, that is, spending on items such as the construction of buildings and equipment for health providers (2 percent), education and training of health personnel (1 percent), and research and development in health (<1 percent) were amongst the lowest.

TABLE 3.9: BREAKDOWN OF EXPENDITURES BY FUNCTION, 2008-2009

Function	Amount (US \$)	Percentage
Services of curative care	612,892,357	58.7
Ancillary services to health care	435,150	<0.1
Medical goods dispensed to out-patients	289,460,437	27.8
Prevention and public health services	56,636,570	5.4
Health administration	52,249,140	5.0
Capital formation for health care provider organizations	18,866,332	1.8
Education and training of health personnel	7,363,603	0.7
Research and development in health	1,623,641	0.2
Not classified by kind	4,293,578	0.4
Total	1,043,820,810	100

¹⁹ Unfortunately, for this exercise hospital costs could not be separated by inpatient and outpatient services due to limitations in the facility-level data.

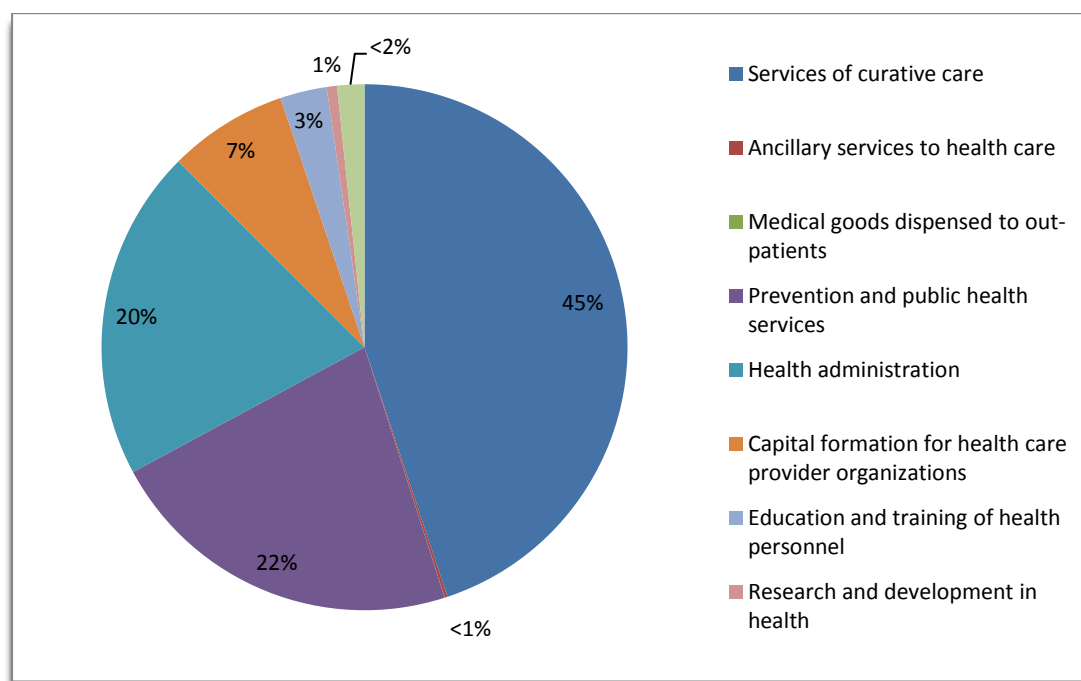
Household expenditures are wholly dedicated to curative care and medical goods. As table 3.10 and Figure 3.11 reveal, if household expenditures are **excluded**, the most significant area of spending remains in curative care (45 percent) followed by prevention and public health services (22 percent).

With maternal mortality and child nutrition indicators amongst the most severe in the world, it is only appropriate that allocations be directed toward this area. Education and awareness on improving reproductive and child health remains critical. Communicable diseases are also beginning to pose a greater threat but when attended to early, they can be inexpensive to treat. This merits a sustained increase in allocations to prevention and public health services.

TABLE 3.10: BREAKDOWN OF EXPENDITURES BY FUNCTION (EXCLUDING HOUSEHOLD EXPENDITURES), 2008-2009

Functions	Amount (US \$)	Percentage
Services of curative care	115,258,776	44.9
Ancillary services to health care	435,450	0.2
Medical goods dispensed to out-patients	17,760	<0.1
Prevention and public health services	56,636,570	22.1
Health administration	52,249,140	20.4
Capital formation for health care provider organizations	18,866,332	7.3
Education and training of health personnel	7,363,603	2.9
Research and development in health	1,623,641	0.6
Not classified by kind	4,293,578	1.7
Total	256,744,552	100.0

FIGURE 3.11: BREAKDOWN OF PUBLIC EXPENDITURES BY FUNCTION (EXCLUDING HOUSEHOLD EXPENDITURES) 2008-2009



4. POLICY IMPLICATIONS

This is Afghanistan's first NHA exercise and its revelations are pertinent and timely as the country enters a period of transition and change. NHA results will be disseminated to a wide range of stakeholders in the hopes that it will motivate discussion and induce policy change.

Some of areas to consider include:

- **Implementing a risk protection mechanism for households.** Households in Afghanistan spend on average US \$31 per capita—or about 6 percent of their annual per capita income—on health. Such high expenses pose severe barriers to accessing healthcare, particularly for the rural poor. Catastrophic payments, in particular, can push households into debt, force them to sell assets, as well as negotiate high-interest payment schemes with providers. In the long-term, some form of prepayment system such as an increased government allocation and expenditure to the health sector, community based-financed schemes, limited social insurance programs, or a combination of all can mitigate some of these effects and increase access to treatment.
- **Promoting rational medicine use.** Pharmaceuticals and other medical non-durables make up the bulk of household health expenses with a significant proportion dispensed through pharmacies and retail shops. Not only are doctors thought to frequently overprescribe medications in the course of treatment, but patients often ask private pharmacies to prescribe medicines though the majority of pharmacies do not have a qualified pharmacist on staff (a significant amount of pharmaceutical products are also thought to be purchased through illegitimate channels).²⁰ While mark-up margins on pharmaceutical products at the import, wholesale, and retail levels have been capped by the government, in reality this has not been enforced well. It is important that MoPH further its plans to survey the retail sector and formulate effective regulatory functions.

While inducing a behavioral change may be difficult in the short-run, the MoPH should consider strengthening and expanding its existing rational medicine use program. This includes boosting its Drug and Therapeutic Committee programs, conducting regular studies of rational medicine use among physicians in the public and private sectors, and expanding its current public education/health messaging for pharmaceutical products. In addition, the MoPH should lead efforts in developing a coordinated drug procurement and supply system—this will improve stock management (and ensure better quality) of essential medicines at all BPHS and EPHS facilities and assist in keeping costs down at what should be “free” public facilities.

- **Conducting a costing study of the BPHS/EPHS.** Given the bulk of resources devoted towards providing a package of “free” services to Afghanistan's citizens, it seems that the cost to individuals is much higher than anticipated. Along with separating by inpatient and outpatient services, it will be important to cost each of the priority services offered within these health care packages and to evaluate each in terms of quality. It is essential to better understand where resource gaps exist and how more cost-efficient delivery can be offered.
- **Investigating revenue generation strategies for the health sector.** Left to its own with no external support, GIRoA spends only US\$2 per capita on health sector activities. This figure is devastatingly low. There are two main reasons for this: (1) in Afghanistan public expenditures in general are very low largely due to its inability to generate domestic

²⁰ Patterson, A., A. Karimi. (2005). *Understanding Markets in Afghanistan: A Study of the Market for Pharmaceuticals*. Afghanistan Research Evaluation Unit.

revenue through traditional methods such as tax collection; and (2) a very small share of public expenditure is devoted to health. Possible remedies include revenue generation through the implementation of corrective taxes, user fees, or some variation of these. But it is important to tread cautiously. Revenue generation for the health sector may impact the labor market—that is, either through reducing employment or pushing individuals into joining the informal sector. Similarly, increasing the budget share devoted to public expenditures on health may reduce expenditures on other areas that have an indirect effect on health such as education.

- **Encouraging private sector involvement.** Despite the availability of the BPHS and EPHS, private facilities are sought out more than public facilities for health services. Because the sustainability of the BPHS and EPHS is wholly dependent on donor funding, it is important that GIRoA begin leveraging the private sector. Achieving public health needs require more effective use of private resources. With health care demands outpacing the supply of services, the BPHS system is incapable of providing treatment to all. Further, the lack of trained female providers poses a supply constraint within the health system. The private sector can be better integrated into the health system to alleviate some of these problems. Initial steps in doing so include establishing regulatory controls and an accreditation system for private providers.

5. INSTITUTIONALIZING NHA

This NHA exercise has been completed in such a manner that it will ease the ability to produce health expenditure data on a regular basis in order to institutionalize the process. The current NHA team is working to transfer knowledge to other staff members within the HEFD, improve its capacity to collect data, and most importantly ensure that NHA results are used to impact policy.

To ensure that institutionalization becomes a reality, Afghanistan must consider the following:

- **Enact and enforce legislation that will mandate production of NHA on a regular basis.** This will facilitate planning for institutionalization and ensure that the necessary financial, human, and technical resources are put in place. For this stage of NHA, a core team of two individuals was involved in collecting and analyzing the data. But a larger, dedicated pool of staff is necessary so that the knowledge is shared and data is collected and analyzed quickly and efficiently.
- **Sustain engagement of the NHA Steering Committee.** The NHA Steering Committee has been valuable in providing guidance over this first NHA exercise. It is critical that this continue. The Steering Committee should represent members from both the public and private sectors, bring awareness to the importance of NHA, and reconcile the interests of those relevant to the NHA process.
- **Develop a standardized mechanism within the MoPH that will allow all stakeholders to easily report their data.** One of the main difficulties faced during this first exercise was obtaining data from donors and NGOs in a systematic and timely manner. Each donor and NGO has a different means of reporting and classifying projects and expenditures—in the case of Afghanistan, where the number of actors in the health sector is sizeable, reconciling these figures can be a challenge. To illustrate, NGOs report to both the MoPH and the donors from which they receive funds—however, the reporting formats that are used for each are not the same. In other words, there is no unified reporting system.

To alleviate this problem, the MoPH is currently working on a system that will permit NGOs to feed in their raw data into a centralized system which in turn will eject the data into a readable format. This should be expanded to include donors and other relevant actors who invest in Afghanistan's health sector.

- **Produce key indicators only.** While it would ideal to collect data on all indicators, this is not always feasible or practical. Select indicators should be prioritized for NHA purposes—in particular, those that can be used to justify increased funding for the health sector; and those that can be used to advance specific policy initiatives. These indicators should be discussed and finalized with the Minister of Public Health and the NHA Steering Committee.
- **Improve household data collection.** Household data collection is never a simple task—problems of oversampling, non-response, and recall bias are rampant. One-time surveys can be costly and ineffective. Therefore, it is critical to obtain a commitment from the Central Statistics Organization (CSO) to include health expenditure questions in its existing household survey at least every other year. Results will be comparable over time and the response rate is likely to be higher and more reliable in a survey which has already been well-established and individuals are already familiar with.

ANNEX 1. 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** is considered as international aid and donor assistance. **HF.3. Rest of the World** includes funds that are channeled through donor agencies.

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 in-patients and the specialised accommodation services required by in-patients. Hospitals may also provide out-patient 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 out-patients who do not require in-patient 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 (i.e. wages, overhead, development of information systems, training activities).
- **HP.8 Institutions providing health-related services** include research centers, academic institutions, and similar entities.
- **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.

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 which 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.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 4. Ancillary services** comprises 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 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 2. NHA MATRICES

Table 1. Afghanistan NHA - Sources of funds for health care and related functions by financing agent, 2008-2009

FINANCING SOURCE X FINANCING AGENT (FS X HF)

	S.1 Public Funds*	FS.2 Private Funds*				FS.3 Rest of the world funds (donors)	Column totals
	S.1.1 Central government revenue	FS.2.1 Employer funds	FS.2.2 Household funds	FS.2.3 Non-profit institutions serving individuals	FS.2.4 Other private funds		
HF.1.1.1.1 Ministry of Public Health	52,180,485					51,306,351	103,486,836
HF.1.1.1.2 Ministry of Defense	5,690,434						5,690,434
HF.1.1.1.3 Ministry of Interior	1,006,724						1,006,724
HF.1.1.1.4 Ministry of Higher Education	4,996,835					366,926	5,363,761
HF.1.1.1.4 Ministry of Education	17,760						17,760
HF.2.3 Private households out-of-pocket			787,076,258				
HF.2.4 Non-profit institutions serving households				2,141,457		48,922,997	51,064,454
HF.2.5. Other private firms						2,419,970	2,419,970
HF.3 Rest of the world (donors)						87,694,612	87,694,612
Total funds provided	63,892,239		787,076,258	2,141,457		190,710,857	1,043,820,810

Table 2. Afghanistan NHA - Allocation to health care payers/ purchasers 2008/2009

FINANCING AGENT X PROVIDER (HF X HP)

	HF.1 General Government					HF.2 Private Sector			HF.3 Rest of the world (donors)	Column totals
	HF.1.1 General government excluding social security funds					HF.2.3 Private households out-of-pocket	HF.2.4 Non-profit institutions serving households	HF.2.5 Other private firms		
	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defense	HF.1.1.1.3 Ministry of Interior	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.4 Ministry of Education					
HP.1 Hospitals	27,010,907	5,640,000	598,801	2,070,229		239,675,625	19,680,373		11,485,947	306,161,881
HP.3 Providers of ambulatory health care	34,775,094			50,000		246,414,475	20,792,580		28,830,534	330,862,683
HP.4 Retail sale and other providers of medical goods					17,760	294,884,323				294,902,083
HP.5 Provision and administration of public health programs							3,100,184		5,255,638	8,355,822
HP.6 General health administration	33,649,185	50,434	407,923				5,080,006	1,562,725	17,944,612	58,694,885
HP.7. All other industries	7,584,148					6,101,835	673,714	86,754	23,127,427	37,573,878
HP.8 Institutions providing health related services *	467,501			3,243,532			1,737,598	770,491	1,050,454	7,269,577
HP.9 Rest of the world										
Total funding provided	103,486,835	5,690,434	1,006,724	5,363,761	17,760	787,076,258	51,064,454	2,419,970	87,694,612	1,043,820,810

Table 3. Afghanistan NHA - Allocation to health care purchasers/functions 2008/2009

PROVIDER X FUNCTION (HP X HC)

	HP.1 Hospitals	HP.3. Providers of ambulatory care	HP.4 Retail sale and other providers of medical goods	HP 5. Provision and administration of public health programs	HP.6. General health administration	HP.7. All other industries	HP.8. Institutions providing all other health-related services	HP.9 Rest of the world	Column totals
HC.1 and HC.2 Services of curative care and rehabilitative care	294,804,457	306,524,967	5,441,647			6,121,287			612,892,357
HC.4 Ancillary services to medical care	198,820	124,040			82,600	29,690			435,150
HC.5 Medical goods dispensed to out-patients			289,460,437						289,460,437
HC.6 Prevention and public health services	13,879	11,335,571		7,746,100	6,842,708	30,549,321	148,991		56,636,570
HC.7 Health administration	3,647,620	479,290			47,997,164		125,066		52,249,140
Plus: HCR.1 Capital formation of health care provider institutions	7,233,531	11,629,819					2,982		18,866,332
Plus: HCR.2 Education and training of health personnel	122,520	505,568		20,000	493,469		6,222,046		7,363,603
HCR.3 Research and development in health		263,428		589,722			770,491		1,623,641
HCnsk Expenditure not specified by kind	141,054				3,278,944	873,580			4,293,578
Total funding provided	306,161,881	330,862,683	294,902,083	8,355,822	58,694,885	37,573,878	7,269,577		1,043,820,810

Table 4. Afghanistan NHA - Allocation to health care payers/functions 2008/2009

FINANCING AGENT X FUNCTION (HF X HC)

	HF.1 General Government					HF.2 Private Sector			HF.3 Rest of the world (donors)	Column totals
	HF.1.1 General government excluding social security funds					HF.2.3 Private households out-of-pocket	HF.2.4 Non-profit institutions serving households	HF.2.5 Other private firms		
	HF.1.1.1.1 Ministry of Public Health	HF.1.1.1.2 Ministry of Defense	HF.1.1.1.3 Ministry of Interior	HF.1.1.1.4 Ministry of Higher Education	HF.1.1.1.4 Ministry of Education					
HC.1 and HC.2 Services of curative care and rehabilitative care	44,312,069	3,880,000	598,801	2,120,229		497,633,581	35,900,418		28,447,259	612,892,357
HC.4 Ancillary services to medical care	121,040								314,110	435,150
HC.5 Medical goods dispensed to out-patients					17,760	289,442,677				289,460,437
HC.6 Prevention and public health services	18,522,763						3,464,680	86,754	34,562,374	56,636,570
HC.7 Health administration	29,998,063	50,434	407,923	125,066			7,556,506	1,562,725	12,548,423	52,249,140
HCR.1 Capital formation of health care provider institutions	6,640,371	1,760,000					1,415,530		9,050,431	18,866,332
HCR.2 Education and training of health personnel	444,390			3,118,466			1,737,598		2,063,150	7,363,603
HCR.3 Research and development in health	263,428						589,722	770,491		1,623,641
HCnsk Expenditure not specified by kind	3,184,712						400,000		708,866	4,293,578
Total funding provided	103,486,835	5,690,434	1,006,724	5,363,761	17,760	787,076,258	51,064,454	2,419,970	87,694,612	1,043,820,810

ANNEX 3. MAJOR DONORS TO AFGHANISTAN'S HEALTH SECTOR

TABLE A1. DONOR CONTRIBUTORS TO AFGHANISTAN'S HEALTH SECTOR

Donor	Amount (US \$)	Percentage
USAID	44,479,366	23.3
World Bank	26,151,787	13.7
EU	25,147,897	13.2
UN	24,699,253	13.0
ISAF	10,770,736	5.6
Global Fund	9,911,356	5.2
GTZ	7,641,059	4.0
GAVI	5,606,699	2.9
CIDA	5,589,931	2.9
JICA	3,384,882	1.8
TICA	2,794,568	1.5
SIDA	2,583,131	1.4
WHO	2,118,493	1.1
Other donors ^{1/}	19,831,699	10.4
Total	190,710,856	100.0

^{1/} This includes contributions from Australia, Brunei, Czech Republic, France, Estonia, Hungary, Italy, Lithuania, Netherlands among other donors.

INTERNATIONAL DONORS

United States Agency for International Development (USAID)

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

A survey was distributed to both implementing NGOs and the Grants and Contracts Management Unit (GCMU) of the MoPH to collect expenditure data (costs of service delivery, administration, overheads, etc.). USAID also provides pharmaceuticals to NGOs through its *Techserve* project—data on expenditures on pharmaceuticals was provided again by the GCMU. In addition, USAID was sent a survey similar to other donors to provide information on its technical assistance projects.

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 is piloting the MoPH Strengthening Mechanism (MoPH-SM) which supports MoPH efforts in delivering these services through “contracting in” management services. Additionally, the World Bank supports a variety of other project in the areas of capacity building, monitoring and evaluation, and disease prevention (including avian influenza and HIV/AIDS). BPHS and EPHS data was collected from implementing NGOs and verified with the GCMU.

European Union (EU)

The European Union (EU) also supports the BPHS and EPHS in 10 provinces through contracting out to 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. Afghanistan's development budget also notes two technical projects funded by the EU.

Note: Several NGOs funded by the EU provided expenditure data in Euros. This was converted to USD at an exchange rate of 1 Euro= 1.46 USD (2008)

- **United Nations (UN)/World Health Organization (WHO)**
 - 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 MoPH but channel their own funds directly. In other cases, they contract technical assistance to NGOs (often those implementing BPHS-EPHS).
 - UNICEF (United Nations Children's Fund): JICA and CIDA have reported that they provide funding to UNICEF projects. However, the expenditures reported by these two agencies are far larger than those reported by UNICEF—we considered only those numbers provided by UNICEF who managed the funds and can better report on actual expenditures (as opposed to the total disbursement from the donor to UNICEF).
 - World Health Organization (WHO): The WHO is engaged in number of different activities ranging from activities promoting child and maternal health to administrative and technical support to the MoPH.
 - World Food Programme (WFP), United Nations Office on Drugs and Crime (UNODC), and the International Committee of the Red Cross (ICRC): though contacted, these agencies did not provide any health expenditure data.

- **International Security Assistance Force (ISAF)**

The International Security Assistance Force (ISAF) and provincial reconstruction teams are based in all provinces of Afghanistan. The majority of ISAF funds are dedicated towards construction activities.

ISAF provided data on assistance channeled to all sectors. The NHA team sorted through each individual project to determine whether it was health related or not in order to conduct the analysis.

- **Canadian International Development Agency (CIDA)**

Canadian International Development Agency (CIDA) provided expenditure data for all projects that were recorded as health related. In cases where CIDA—a major donor for polio eradication efforts—provided funds to WHO and UNICEF, expenditures were recorded under those donors.

Note: Expenditure data was provided in Canadian dollars. This was converted to USD at an exchange rate of 1 Canadian dollar= 0.90 USD (2008)

- **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 leads a number of projects promoting health awareness and education.

- **Turkish Agency for International Cooperation (TICA)**

Data was collected from the Turkish Agency for International Cooperation (TICA). Assistance was geared primarily toward improving the management of hospitals and outpatient care centers.

- **Swedish International Development Agency (SIDA)**

The Swedish Committee for Afghanistan provided expenditure data on all Swedish International Development Agency (SIDA) health sector projects. The majority of projects were dedicated toward physical rehabilitation for disabled persons.

LOCAL DONORS

- **Afghanistan Red Crescent Society (ARCS)**

The Afghanistan Red Crescent Society (ARCS) is an independent Afghan governmental body, which runs outpatient care centers and hospitals and helps patients with congenital health problems travel overseas for treatment. It is also involved in community first aid and other health related projects. The ARCS obtain funds through a number of different fundraising activities (including lotteries, charity, donor funding, customs tax). The ARCS Health Services Director is a member of the NHA Steering Committee. **Because ARCS is not an international body (“Rest of the World”), under financing sources and financing agents, ARCS is classified as a “non-profit institution serving households.”**