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SHA-Based Health Accounts in the Asia/Pacific Region : Afghanistan 2011-2012

Mir Najmuddin Hashimi, Shuhrat Munir, Mohammad Saber Perdes and Ahmad Shah Salehi

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SHA Technical Papers

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The development of Afghanistan's National Health Accounts (NHA) report for financial year 1390 (2011–2012) has only been possible through the intensive efforts of 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) with the Contributions from donors, nongovernmental organizations, and numerous other government ministries and agencies funded the NHA report.

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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.

SUMMARY

In recognition of the potential policy impacts of consistent NHA data, Afghanistan 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.

Total Health Expenditure (THE) in 2011–2012 was USD 1,501.0 million. This represents a significant 43.8 percent increase since the first round of NHA in 2008–2009. With health expenditure growing at a lower rate than overall GDP, however, THE as a percentage of Gross Domestic Product (GDP) decreased from 10.0 to 8.0 percent over the three-year period. Total government expenditure on health rose 31.7 percent over the three-year period, reaching USD 84.1 million in 2011–2012.This represents a 0.2 percentage point 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 1,104.4 million in 2011–2012. This accounted for nearly three-quarters (73.6%) of all health spending. By contrast, the central government financed 5.6 percent (USD 84.1 million) of health expenditures in 2011–2012. International donor funding accounted for the remaining 20.8 percent (USD 312.5 million) of THE.

In 2011–2012, 73.3 percent (USD 1,099.5 million) 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 218.9 million or 14.6 percent of THE. The central government—through the Ministry of Public Health, Ministry of Defense (MoD), Ministry of the Interior (MoI), Ministry of Higher Education (MoHE), and Ministry of Education (MoE)—controlled 11.8 percent (USD 177.8 million) of THE. Finally, non-profit institutions serving households were responsible for managing 0.3 percent (USD 218.9 million) 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 25.8 percent (USD 387.7 million) 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 25.3 and 24.4 percent of THE, respectively, in 2011–2012. Retail providers of medical goods deliver the largest portion of services indicating the lack of availability of medical supplies and pharmaceuticals at formal health facilities across the country.

In 2011–2012, services of curative care, including inpatient and outpatient services, accounted for 37.0 percent of THE. This reflects the rollout of MoPH's Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) that expanded curative coverage to households. An estimated USD 322.1 million (21.5 percent of THE) was spent on inpatient care while USD 232.8 million (15.5 percent of THE was spent on outpatient care. Medical goods dispensed to outpatients accounted for 25.8 percent (USD 387.7 million) of THE in 2011–2012. Ancillary services, such as medical and diagnostic imaging, accounted for almost one-quarter (23.7 percent) of expenditures (USD 356.1 million) in 2011–2012.

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
GoIRA	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	Organization 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

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1. INTRODUCTION

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 (GoIRA, 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 (GoIRA, 2013). Less than 3 percent of the population is age 65 and older, with the estimated life expectancy at birth being 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, the country has undergone significant transition. 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 (GoIRA, 2013). This represents a 74.7 percent increase from 2010. Policymakers are optimistic that improvements in the national health system will accompany greater economic growth.

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 a relatively high 5.1 children born per woman, with 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, the limited number of female health care providers (who are needed for reproductive health care for religious reasons), and the limited role of females as decision makers in their own health care (GoIRA, 2012c).

The health services in Afghanistan operate at three following levels:

1) Primary Care Services i.e. at the community or village level as represented by health posts, CHWs, SHCs, BHCs and MHTs;

2) Secondary Care Services i.e. at the district level, as represented by CHCs and District Hospitals operating in the larger villages or communities of a province; and

3) Tertiary Care Services i.e. the provincial, regional and national hospitals.

After 2002, MoPH took the decision, with the support of donors, to change its role to a stewardship role. The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) were developed which resulted in expanding the coverage of health services from 9 percent to around 61-85 percent. Beside the primary health services around 57 percent of the population have access to EPHS Services.

In March 2003, (MoPH) of Afghanistan released the Basic Package of Health services (BPHS), the culmination of a process that determined priority health services to address the population's most immediate needs. This package included the most needed primary health care services at the health post and health center levels of the health system. BPHS provides a standardized package of health services and to respond to the fragmentation and low coordination of the efforts of different agents. The BPHS comprises of a set of high-impact interventions directed to address the major health problems of the population, highlighting on the health of women and children, the two most vulnerable groups.

With the intention of having a common language between the MoPH and the partners in providing the basic health services under the BPHS, a standardized classifications of health facilities [Health Posts (HPs), Health Sub-Centers (HSCs), Basic Health Centers (BHCs), Mobile Health Teams (MHTs), Comprehensive Health Centers (CHCs), District Hospitals (DHs)] were developed (MoPH, A Basic Package of Health Services for Afghanistan, 2010).

Following the successful implementation of BPHS, in 2005 MoPH added the Essential Package of Hospital Services (EPHS) to the system, focusing on hospitals, improving their facilities, equipment, training staff and by enhancing the referrals between different levels of the health system. EPHS as one of the major programs of the Afghanistan Ministry of Public Health aims to provide advanced health services in hospitals. It also serves as a primary referral point for primary health care facilities.

EPHS has the three main purposes:

1. Identify the standard package of hospital services
2. Provide guidance on staffing, equipment, materials and drugs by hospitals for MoPH, donors, Non-Governmental Organizations (NGOs); and
3. Promote referral system from BPHS to hospitals

In EPHS and BPHS, hospitals according to the size, number of beds, referral population complexity of services and workload are classified into the three following groups (MoPH, The Essential Package of Health Services, 2005):

- District Hospital (DH) part of BPHS
- Provincial Hospital (PH) or
- Regional Hospital (RH)

1.2. 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 (GoIRA, 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 where improvements might be possible through changes in national health policies. Among other impacts, the findings lead to 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 (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 1.3.

1.3. 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 of the second round of NHA 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

2. General NHA Findings

2.1. 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 ability to compare spending from year to year provides extra valuable information to policy makers. With the findings from 2011–2012, policymakers have the ability to evaluate spending over time and compare the outcomes with the 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 decision makers determine trends and better evaluate the successes and areas of improvement within the health sector.

2.2. Summary Statistics of General NHA

Table 2.1 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. It is worth mentioning, as NHA analysts build their technical expertise and become more comfortable with the methodology, they are able to make better decisions for how 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 the country's first and second round of NHA. Over a three-year interval, GDP at current prices in Afghanistan increased by about 74.7 percent, according to the CSO (from USD 10,843.3 million to USD 18,952.0 million). THE at current prices also grew dramatically, increasing 43.8 percent from USD 1,043.8 million in 2008–2009 to USD 1,501.0million in 2011–2012. With health expenditure growing at a lower rate than overall GDP, however, THE as a percentage of GDP, decreased from 10.0 to 8.0 percent over the three year period. Total government health expenditure rose 31.7 percent over the three year period This represents a 0.2 percentage point increase in total government health expenditures as a percentage of total government expenditures (from 4% to 4.2%). Private households remain the main financier of the Afghanistan health system, accounting for nearly three-quarters (73.3%) of all health spending in 2011–2012. Household OOP per capita spending 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 25.8 percent. Finally, services of curative care, including inpatient and outpatient services, remain the largest health function and accounted for 37.0 percent of THE. Some figures in the summary table will be discussed in greater detail in subsequent sections.

Table 2.1. Summary of General NHA Findings, 2008–2009 & 2011–2012

NHA Indicators	2008–2009	2011–2012
General		
Total population	25,011,400	27,000,000
GDP (million USD)	10,843.3	18,952.0
Average exchange rate (USD: Afs)	1:50	1:47
Total government health expenditure (million USD)	63.8	84.1
Total health expenditure (THE) (million USD)	1,043.8	1,501.0
THE per capita (USD)	41.73	55.59
THE as % of real GDP	10%	8%
Government health expenditure as % total government expenditure	4%	4.2%
Percentage share of THE by financing source		
Central government	6%	5.6%
Private	76%	73.6%
Rest of the World	18%	20.8%
Household (HH) Spending		
Total HH (OOP) spending as % of THE	75%	73.3%
Total HH (OOP) spending per capita (USD)	31.4	40.7
Percentage share of THE by financing agent		
Central government	11%	11.8%
Household	75%	73.3%
Non-profit institutions serving households	5%	0.3%
Rest of the World	8%	14.6%
Percentage share of THE by provider		
Hospitals	29%	24.4%
Outpatient care centers	32%	25.3%
Retail sale and other providers of medical goods	28%	25.8%
Other[1]	11%	24.5%
Percentage share of THE by function[2]		
Curative care	59%	37%
Pharmaceuticals	28%	25.8%
Prevention and public health programs	5%	5%
Health administration	5%	6.2%
Capital formation	2%	1.2%
Ancillary Services	-	23.7%
Other[3]	1%	1%

1 Provision and administration of public health programs, general health administration, and all other industries are included in other/provider.

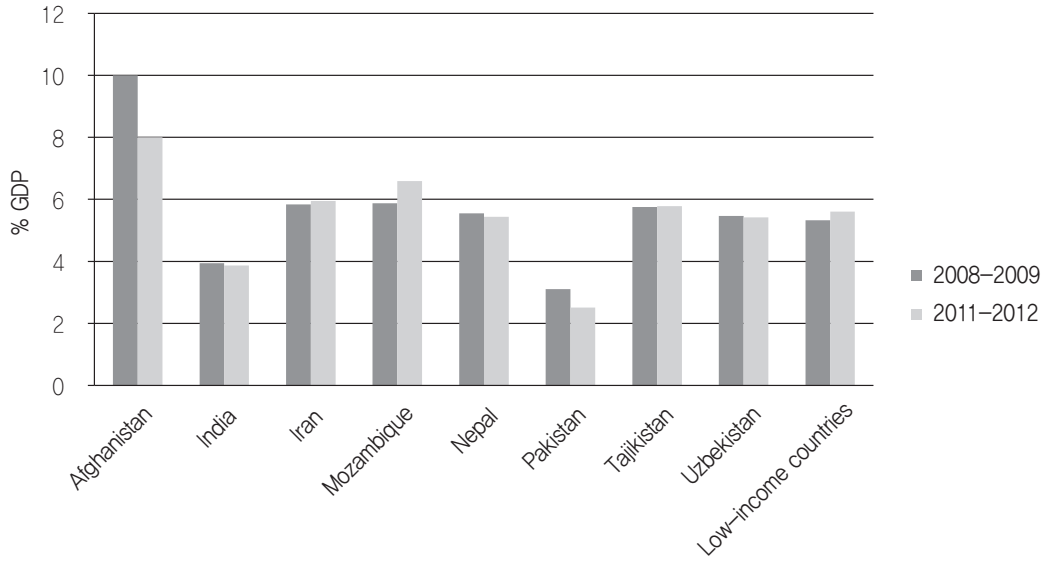
2 Comparison of functions across years may not be possible due to the significant changes in classification, which allows for a more detailed breakdown.

3 Other services include rehabilitative care and health functions not specified by kind.

2.3. International Comparison

Afghanistan dedicated 8 percent of its GDP to health expenditures in 2011–2012. This represents a 2 percentage point decrease compared to 2008–2009. However, over the three-year period, as shown in Figure 3.1, Afghanistan contributed more of its GDP to health than its neighbors and income peers. The average percentage of GDP spent on health in low-income countries was 5.6 percent in 2011–2012, increasing only slightly from 5.3 percent in 2008–2009. Afghanistan's relatively high health expenditure may be due to the high rates of OOP spending (73.3%) in the country 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).

Figure 2.1. 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.

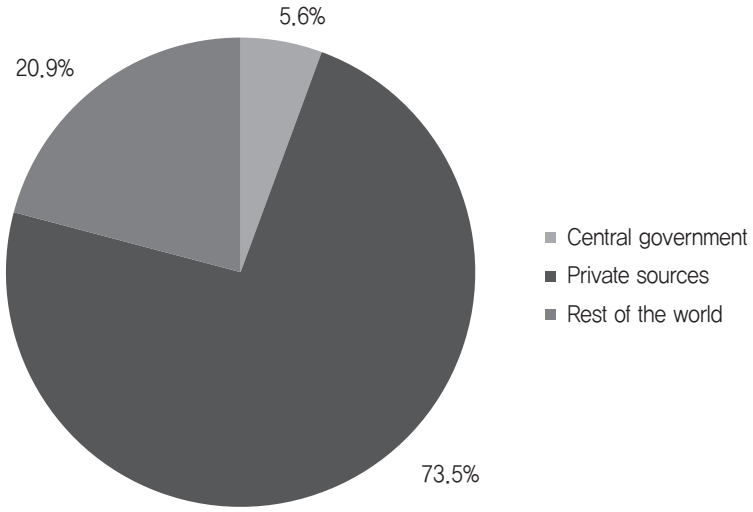
2.4. Financing Sources: Who Pays for Health Care?

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 Table 2.2 and Figure 3.2, in 2011–2012 private sources were the major financier of the health system, contributing nearly three-quarters of health funding (73.6 percent). Individual households through direct OOP payments made to health providers financed the vast majority of this component (73.3 percent of THE). This component decreased only slightly from 76 percent in 2008–2009. The central government financed 5.6 percent of health expenditures in 2011–2012, down from 6 percent in 2008-2009. International donor funding increased slightly from 18.0 percent of THE in 2008–2009to 20.8 percent of THE in 2011–2012. The Afghanistan Red Crescent Society (ARCS) is classified as "non-profit institution serving household", which contributed 0.3 percent of THE in 2011-2012.

Table 2.2. Breakdown of health expenditures by financing source, 2011–2012

Financing source	Expenditure (million USD)	%
Central government	84.1	5.6%
Private sources	1,104.3	73.6%
Households	1,099.5	73.3%
Non-profit institutions serving households	4.8	0.3%
Rest of the world	312.4	20.8%
Total	**1,500.8**	**100%**

Figure 2.2. Percentage share of health expenditures by financing source, 2011–2012



2.4.1. 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 787.1 million to USD 1,099.5 million. This represents a 39.7 percent increase in spending over the three-year period. Since the public and private insurance sectors are underdeveloped in Afghanistan, all household expenditures on health 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 payments for medicine or transportation.

2.5. Financing Agents: Who Manages Health Funds?

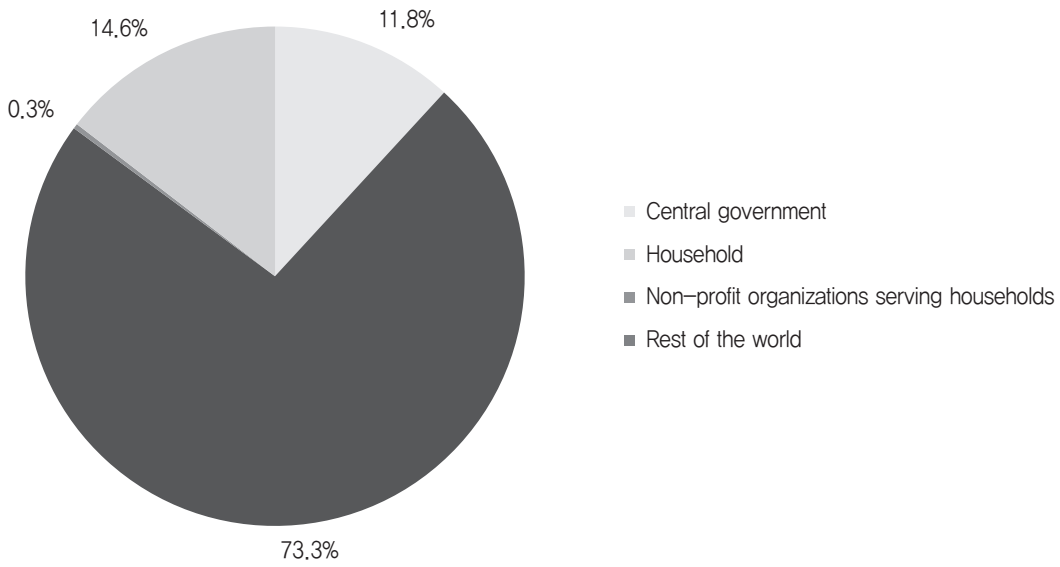
Financing agents are the entities responsible for managing health funds. They receive resources from financing sources and distribute them to health providers. Financing agents are not just intermediaries of the health system; instead, they are crucial entities that maintain programmatic control over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

Table 2.3 and Figure 3.3 show 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, a large financial burden continues to fall on households as managers of health funds. The role of international donors as financing agents increased over the three-year period. In 2011–2012, donors controlled USD 218.9 million 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 177.8 million). This represented an increase of 0.8 percentage points 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 2-3. Breakdown of health expenditure by financing agent, 2011–2012

Financing agent	Expenditure (million USD)	%
Central government	177.8	11.8%
Ministry of Public Health	162.1	10.8%
Ministry of Defense	8.5	0.6%
Ministry of the Interior	5.9	0.4%
Ministry of Higher Education	1.0	0.1%
Ministry of Education	0.2	0%
Households	1,099.5	73.3%
Non-profit institutions serving households	4.8	0.3%
Rest of the world	218.8	14.6%
Total	**1,500.8**	**100%**

Figure 2.3. Percentage share of health expenditue by financing agent, 2011–2012



2.6. Health Providers: Who Uses Health Funds to Deliver Care?

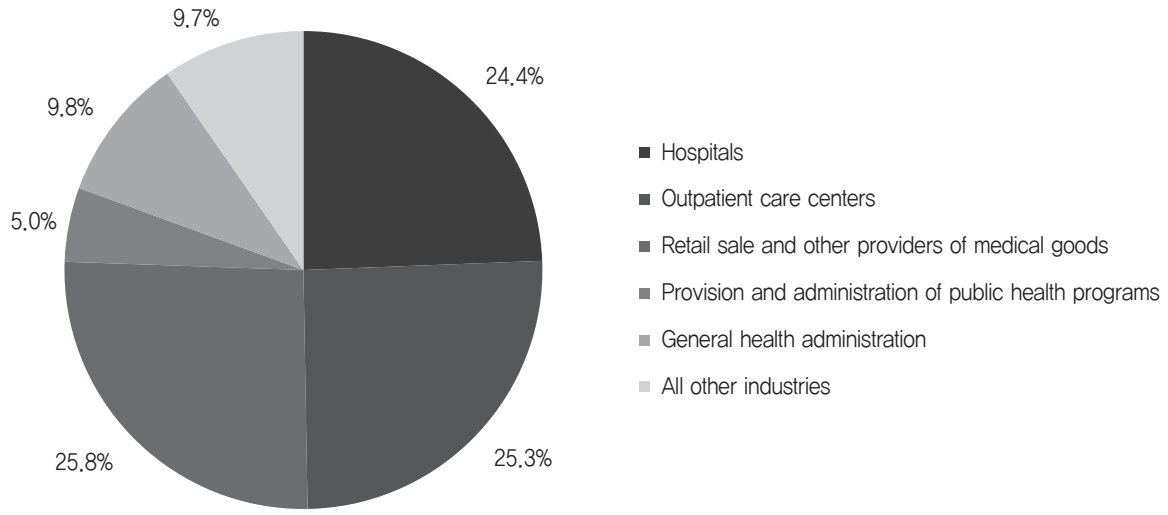
Providers of health care are defined as those entities or institutions that receive funding in exchange for producing a good or service meant to improve or maintain the health and well-being of an individual. There are many types of providers currently operating in Afghanistan including both public and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

In 2011–2012, as shown in Table 2.4 and 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. Outpatient care centers and hospitals provided broadly comparable levels of care in 2011–2012 with 25 and 24 percent of THE, respectively. This represents a 1.6 percentage point decrease since 2008–2009 for hospitals and an 8.7 percentage point 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 2.4. Breakdown of health expenditure by provider, 2011–2012

Provider	Expenditure (million USD)	%
Hospitals	366.1	24.4%
Outpatient care centers	380.2	25.3%
Retail sale and other providers of medical goods	387.7	25.8%
Provision and administration of public health programs	75.4	5%
General health administration	146.8	9.8%
All other industries	144.9	9.7%
Total	**1,501.1**	**100%**

Figure 2.4. Percentage share of health expenditure by provider, 2011–2012



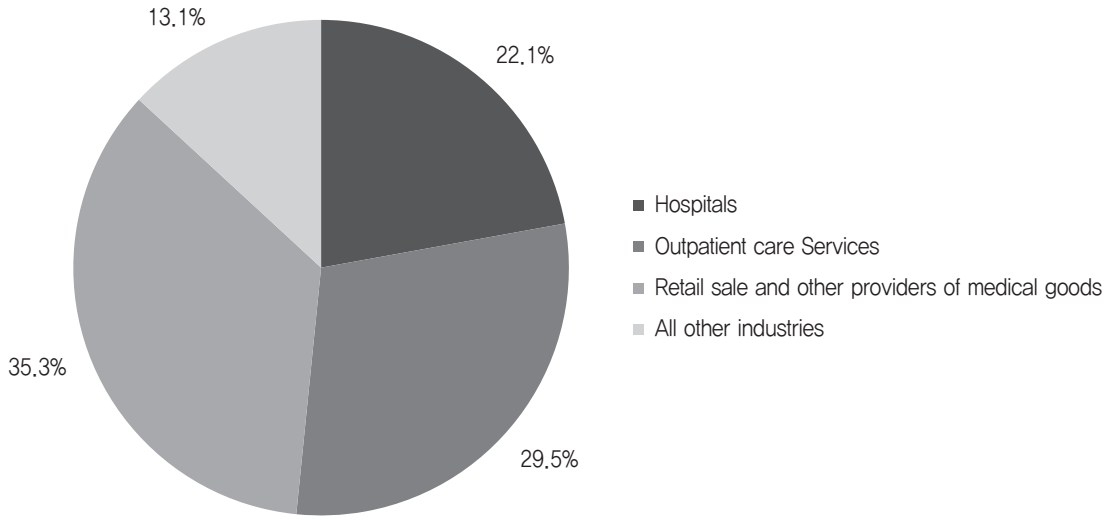
2.6.1. Which Providers Consume Household OOP Funds?

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. Table 2.5 and Figure 2.5 describe 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 estimates of 38 percent. Outpatient care services provided the second largest percentage of services, accounting for 29.5 percent of OOP expenditures with outpatient care centers (10.2%) and medical and diagnostic laboratories (19.2%) contributing to this total. Outpatient care services 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 unable to access some health services from BPHS and 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 period. Finally, the National Risk and Vulnerability Assessment (NRVA) asked households for the amount spent on ancillary costs related to their health care, such as transportation. This assessment was used to derive an aggregate sum under the category 'all other industries as secondary producers of health care' - which accounted for 13.1 percent of OOP expenditures.

Table 2.5. Breakdown of OOP expenditure by provider: 2011–2012

Provider	Expenditure (million USD)	%
Hospitals	243.5	22.1%
Outpatient care services	323.8	29.5%
Outpatient care centers	112.2	10.2%
Medical and diagnostic laboratories	211.6	19.2%
Retail sale and other providers of medical goods	387.7	35.3%
Vision products	4.9	0.4%
Hearing products	1.4	0.1%
Medicine	381.3	34.7%
All other industries as secondary producers of health care	144.5	13.1%
Total	**1,099.5**	**100%**

Figure 2.5. Percentage share of OOP expenditure by provider: 2011–2012



2.6.2. 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 2.6, 61.8 percent of OOP payments were made to private facilities—of which 38.2 percentage points went to inpatient department (IPD) services and 23.5 percentage points went to outpatient department (OPD) services. Public facilities received 38.2 percent of household OOP payments—of which 27.6 percentage points went to IPD services and 10.6 percentage points went to OPD services. Overall, the majority of OOP payments for both public and private facilities have gone to IPD services. Table 2.6 also shows the distribution of payments for pharmaceuticals—42.9 percent at public facilities and 57.1 percent of payments at private facilities. The significant percentage of payments relating to pharmaceuticals at public facilities may be attributed to limited medicine availability at public facilities and/or over-prescription of medicines - thereby forcing patients to purchase out of pocket in the private sector.

Table 2.6. Breakdown of OOP expenditures by public and private facilities, 2011–2012

	Total OOP		**Pharmaceuticals OOP**	
Provider	*Expenditure (million USD)*	*%*	*Expenditure (million USD)*	*%*
Public facilities[4]	420.3	38.2%	163.4	42.9%
IPD	303.6	27.6%	105.6	27.7%
OPD	116.8	10.6%	57.8	15.2%
Private facilities[5]	679.2	61.8%	217.9	57.1%
IPD	420.4	38.2%	110.1	28.9%
OPD	258.8	23.5%	107.9	28.3%
Total	**1,099.5**	**100%**	**381.4**	**100%**

4 Public facilities: national hospitals, regional hospitals, provincial hospitals, district hospitals, comprehensive health centers, NGOs, mosques, nursing homes, and other public health facilities.

5 Private facilities: private hospitals, private clinics, pharmacies, other private health facilities, and health facilities abroad (when not disaggregated).

Table 2.7 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 75.6 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 2.7 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.

Table 2.7. Breakdown of Other OOP expenditure (million USD), 2011–2012

Breakdown of other OOP expenditures	
Transportation	75.6
Food	69
OOP spent for health seeking abroad	
IPD abroad	255.9
OPD abroad	29.5
Total OOP abroad	**285.4**
OOP payments abroad as percentage of total OOP	26%
OOP payments abroad as percentage of THE	19%

2.6.3. Use of MOPH Funding by Providers

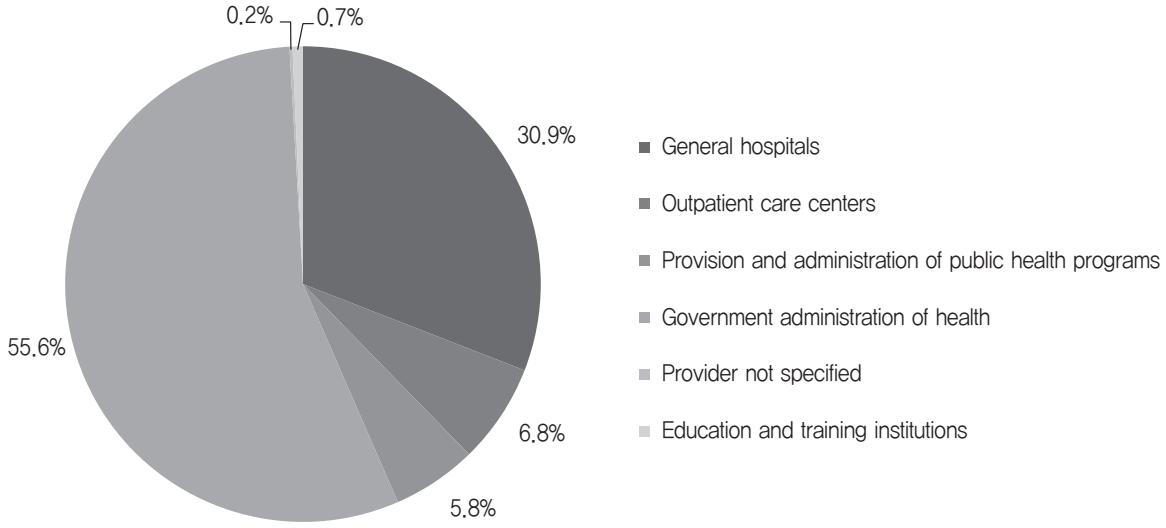
As described in Table 2.8 and Figure 2.6, government administration of health was the largest provider of services using MoPH funds, accounting for 55.6 percent of total MoPH funds in 2011–2012. As noted above, general administration consists of costs at the central and provincial levels that are associated 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 user 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 can 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 consumers' use of health facilities, including greater use of hospitals for outpatient services in urban areas.

Finally, it is worth mentioning that MoPH does allocate some funding (USD 1.2) to institutions providing health-related services, including education and training institutions. The NHA allows 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, health. Since they are not direct health expenditures, they are not included in THE. They are, however, included as part of the National Health Expenditure (NHE) for the MoPH.

Table 2.8. Breakdown of MoPH expenditure by provider, 2011–2012

Provider	Expenditure (million USD)	%
General hospitals	50.5	30.9%
Outpatient care centers	11.1	6.8%
Provision and administration of public health programs	9.4	5.8%
Government administration of health	90.8	55.6%
Provider not specified	0.3	0.2%
Sub-Total	**162.1**	**99.3%**
Education and training institutions	1.2	0.7%
Total MoPH Funds	**163.3**	**100%**

Figure 2.6. Percentage share of MoPH expenditure by provider, 2011–2012



2.7. 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 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.

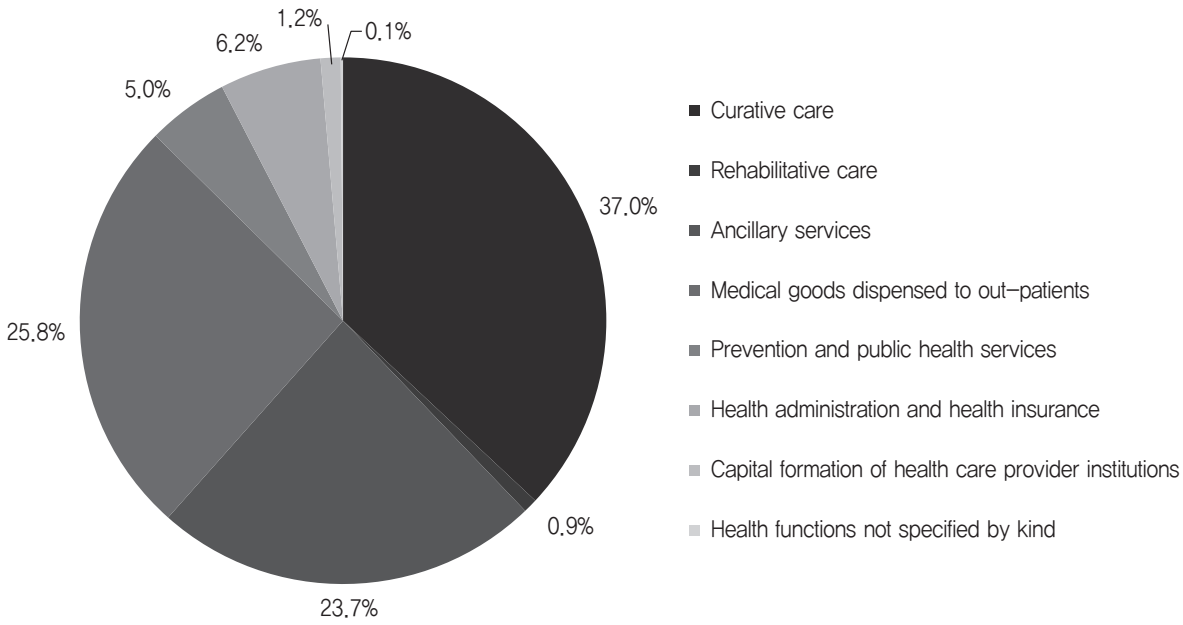
Table 2.9 below details the breakdown of health functions for THE in 2011–2012. Services of curative care, including inpatient and outpatient services, accounted for 36.6 percent of THE. This represents a 22 percentage point decrease from 2008–2009. Medical goods dispensed to outpatients accounted for 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 2.9. Breakdown of health expenditure by function, 2011–2012

Function	Expenditure (million USD)	%
Curative care	554.9	37%
Inpatient curative care	322.1	21.5%
Outpatient curative care	232.3	15.5%
Rehabilitative care	13.1	0.9%
Ancillary services	356.1	23.7%
Medical goods dispensed to outpatients	387.7	25.8%
Prevention and public health services	75.1	5%
Health administration and health insurance	93.5	6.2%
Capital formation of health care provider institutions	18.4	1.2%
Health functions not specified by kind	2.1	0.1%
Total	**1,500.9**	**100%**

Figure 2.7. Percentage share of health expenditure by function, 2011–2012



2.7.1. What Goods or Services are purchased with Funding from the Central Government and International Donors?

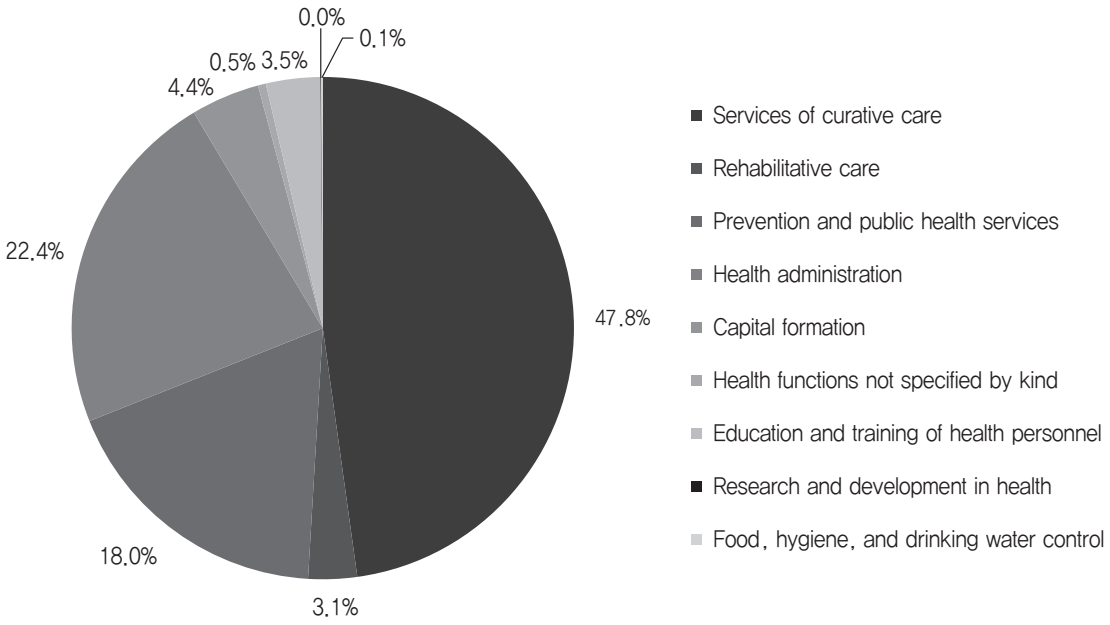
Table 2.10 and Figure 2.8 below describe the breakdown of health functions for those components of expenditure funded by the central government and international donors only (that is excluding expenditure funded by the private sector). Almost half of all expenditures (47.5%) were spent on curative care, 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 18.2 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 2.10. Breakdown of health expenditures (excluding household OOP) by function

Function	*Expenditure (million USD)*	*%*
Services of curative care	199.2	47.8%
Rehabilitative care	13.1	3.1%
Prevention and public health services	75.2	18%
Health administration	93.5	22.4%
Capital formation	18.4	4.4%
Health functions not specified by kind	2.1	0.5%
Education and training of health personnel	14.6	3.5%
Research and development in health	0.2	0%
Food, hygiene, and drinking water control	0.4	0.1%
Total	**416.7**	**100%**

Figure 2.8. Percentage share of health expenditures by function for components funded by Central Government and International Donors only



3. Conclusions

As the public sector focuses on reform after several decades of conflict, there have been noteworthy improvements in the overall economy (as reflected in 74.7 percent increase in GDP over the three year period up to 2011-12) as well as increased spending in the health sector. However, despite increases in health spending of 43.8 percent, THE as a percentage of GDP decreased 2 percentage points over this three year period reflecting the very strong growth in the overall economy. Government expenditure on health as a percentage of total government expenditure has remained constant over this period. The burden of financing the health system falls largely on individual households. While households' percentage of THE dropped slightly over the three-year period, absolute spending increased from USD 787.1 million to USD 1,099.5 million, representing a 39.7 percent increase. With little access to insurance, households have financed their health care out of their own pockets. These direct OOP payments raise equity issues and the extent of access to essential health services - especially among the poorest households - can be questioned.

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 available in the public sector, including lack of medical supplies and pharmaceuticals available at health facilities across the country. The difficulties in locating medical supplies and pharmaceuticals may be due to over-prescription by doctors or self-prescription by patients. Inpatients are often required to purchase their own medication from private pharmacies before returning to hospitals for treatment. Shortages of medical supplies and pharmaceuticals at public facilities can serve as a motivation for individuals to seek care at private facilities, despite the BPHS and EPHS offering free health services.

Annex A. Methodology

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)

Data Collection

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.

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[6] returned completed survey questionnaires. NGOs act in different capacities as identified by the NHA; they can be public providers, agents, and financing sources (minimal).

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 MoD, MoI, MoE, 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.

Household Survey

According to health accounting methodology, 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.

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

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

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.

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 (GoIRA, 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.[7]

7 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.

Annex B. SHA BASED NHA Matrices

Table B1. Afghanistan General NHA—health expenditure by financing source and 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 Defense	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%
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%**
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%**	

Table B2. Afghanistan General NHA—Health expenditure by financing agent and 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%
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%
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%**
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—Health expenditure by provider and by 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 administration of public health programs	HP.6 General health administration	HP.7.3 All other industries as secondary producers of health care	HP.nsk Provider not specified by kind	Row total (THE)	HP.8 Institutions 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%
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%**
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%**	**100%**			

Table B4. Afghanistan General NHA—Health expenditure by financing agent and by 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%
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%
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%
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%

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.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%**
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%**	**73.3%**	**0.3%**	**14.6%**	**100%**	

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