Promoting the Institutionalization of National Health Accounts

A Global Strategic Action Plan

October 2010

Conference Volume

Human Development Network
The World Bank
Preface

This conference volume is an abbreviated form of the report, “Promoting the Institutionalization of National Health Accounts: A Global Strategic Action Plan.” It has been prepared for discussion at the Global Consultation: Promoting the Institutionalization of National Health Accounts in Washington, DC on October 20–21, 2010. This two-day meeting will focus on discussions among country participants and development partners. It will aim to secure agreement on those strategies that will work best at country, regional, and global levels.

Feedback and comments received during the Global Consultation will be incorporated into the final version of the Global Strategic Action Plan.

This report has been prepared by a World Bank team and benefited from extensive consultations and guidance provided the Internal NHA Steering Committee (ISC) of the World Bank, and the NHA Technical Advisory Group (TAG). (A comprehensive list of acknowledgments is presented in Appendix 1.)

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I. Introduction

1. The National Health Accounts (NHA) are a widely used and globally recognized framework for measuring the total volume of expenditure and for tracking the flow of funds in a country’s health system. The standardized NHA framework allows for the production of comparable and comprehensive country-level information on the generation, allocation, and utilization of health system resources. NHA offers a rigorous methodology for the accounting of the flow of health funds from different financing sources to different entities that determine how the funds are spent, and allows for the disaggregation of total health expenditure by end use, provider type, and beneficiary subgroup.

2. The Global Strategic Action Plan (GSAP) has been developed through a broad consultative process to facilitate the institutionalization of National Health Accounts (NHA). The GSAP answers the following questions: (i) Why is NHA institutionalization important? (ii) What is NHA institutionalization and how is it measured? (iii) What are the constraints to institutionalizing NHA in developing countries? and (iv) What strategies can be adopted at country, regional, and global levels to overcome the constraints to NHA institutionalization? The GSAP helps to plan actions and strategies required of countries, regional bodies, and international development partners to institutionalize NHA.

3. The GSAP aims to support national policy makers as well as their regional and global partners in the following: (i) reorient their thinking from a project-based approach geared toward producing one-time NHA estimates, to build processes and institutions; (ii) create long-term commitment for resource tracking in the health sector; (iii) assess constraints and develop strategies for institutionalizing NHA; and (iv) provide a framework and platform for regional and international agencies to work together with countries. It strives to improve the evidence base for tracking resource flows in the health sector, which in turn helps countries document resource gaps, effectively advocate for additional funds, and channel money to priority areas. In an era of tightening funding, the need for NHA has never been more important for countries. The GSAP will also benefit development partners, who, faced with a plethora of global agendas and competing priorities, need to better rationalize their own allocations to the health sector.

4. The framework for NHA institutionalization focuses on the following seven core dimensions (see Section III): environment and governance structure, human and financial resources, data collection, data management, data quality, information products, and dissemination and use of NHA data. The framework explains how countries can build stronger systems to gather, manage, analyze, and distribute health expenditure information.

5. The GSAP aims to ensure that 100 countries (from current 41) institutionalize NHA by 2020. To meet this optimistic target, US$ 150 million
will be required over the next 10 years. While this may appear to be a considerable amount in aggregate, a recent World Bank analysis (conducted as part of this report) suggests that institutionalization can lower per country NHA production costs by as much as 66 percent. Additionally this will require country ownership, long-term planning, and commitment on the part of all stakeholders.

6. The importance of NHA to policy makers and development partners has led to an ever-increasing number of countries producing and utilizing health expenditure data. Credit for this dramatic increase goes to the national governments that have recognized the value of NHA, to individual country champions, to regional agencies (through knowledge sharing), and to the international development partners that have provided financial and technical support. Through countries’ and partners’ combined efforts, NHA data are increasingly being used to inform policy questions (Box 1).

### Box 1. Using Health Expenditure Information (HEI) for Policy Formulation

A World Bank global survey on use of health expenditure information among 45 NHA-producing countries envisaged six main classes (box table) of use of health account information by country. Most countries were found to use the information for health policy formulation, especially problem identification.

Health expenditure information, when used in conjunction with a health information system (HIS), vital statistics, facility-level data, epidemiological data, health output and outcome data, subnational data, demographic survey data, and the Development Assistant Database of the Organisation for Economic Co-operation and Development (OECD), can inform policy and decision making.

<table>
<thead>
<tr>
<th>Health Policy</th>
<th>Planning, Budgeting and Financial Sustainability</th>
<th>Tracking Resources</th>
<th>Equity Across...</th>
<th>Efficiency of Health Spending</th>
<th>Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda setting</td>
<td>Planning budgetary decision making</td>
<td>Tracking expenditures by, for example:</td>
<td>Age Ethnictiy and race</td>
<td>Allocative efficiency</td>
<td>Child health</td>
</tr>
<tr>
<td>Health reform</td>
<td>Budgetary decision making</td>
<td>provider</td>
<td>Gender</td>
<td>Technical efficiency</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Problem identification</td>
<td>Allocating resources among competing priorities</td>
<td>disease groups</td>
<td>Regions</td>
<td>Cost containment</td>
<td>Malaria</td>
</tr>
<tr>
<td>Policy advocacy</td>
<td>Ensuring financial sustainability</td>
<td>functions</td>
<td>Incomes</td>
<td></td>
<td>Non-communicable diseases</td>
</tr>
<tr>
<td>Policy dialogue</td>
<td>Also used in the following tools: Fiscal space</td>
<td>inputs</td>
<td>Socio-economic</td>
<td></td>
<td>Reproductive health</td>
</tr>
<tr>
<td>Policy design</td>
<td>analysis, MBB, MTEF, PET, PRSP, SWAp</td>
<td>Tool to promote transparency and accountability</td>
<td>status</td>
<td></td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Policy implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Risk pooling, purchasing, and resource mobilization</td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

*Note: MBB = Marginal Budgeting for Bottlenecks, MTEF = medium-term expenditure framework, PET = public expenditure tracking, PRSP = poverty reduction strategy paper, SWAp = Sector-wide Approach.*

II. Defining and Measuring NHA Institutionalization

7. **For the purposes of the GSAP**, NHA institutionalization is defined as:
   Routine government-mandated production and utilization of a minimum set of globally agreed health expenditure data using a standard health accounting framework.

8. There has been little headway in measuring NHA institutionalization in most countries, primarily due to the lack of in-depth research in the area. No precise definitions exist; and measures for NHA institutionalization are primarily based on the number of years of NHA data produced and/or the number of times that the NHA exercise/project has been conducted. But, as we detail below, these are not the only factors that constitute NHA institutionalization.

9. **Country progress toward institutionalization has been assessed based on four simple criteria.** These are (i) consistent use of NHA data; (ii) adequate financial, human, and infrastructure capacity to routinely produce and use health accounts; (iii) consistent production of NHA data; (iv) use of health accounts methodology. Countries have been grouped into the following stages based on the number of criteria they meet: I: Institutionalized; II: Almost institutionalized; III: Insufficient progress toward institutionalization; and IV: Little or no prior experience with NHA production. Figure 1 provides the status on where countries stand today.

![Figure 1. Countries in Varying Stages of NHA Institutionalization](image)

Source: Authors’ analysis.
10. A more objective measure with 12 qualitative and quantitative indicators to assess institutionalization status is based on five key elements of NHA institutionalization (Table 1).

**Table 1. Indicators to Measure NHA Institutionalization**

<table>
<thead>
<tr>
<th>Criteria for Institutionalization</th>
<th>Key Elements</th>
<th>Indicators</th>
<th>Type of Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent use of NHA data</td>
<td>Data are utilized and disseminated</td>
<td>NHA data are integrated with HIS or national statistical systems</td>
<td>Ordinal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHA data are used for reporting health expenditures in government documents</td>
<td>Ordinal</td>
</tr>
<tr>
<td>Adequate financial, human, and institutional capacity to routinely produce and use health accounts</td>
<td>NHA is government mandated</td>
<td>Core data are available publicly on website</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Law/regulation mandating production</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Institutional home” identified for NHA</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Government budget earmarked for NHA activities</td>
<td>Binary</td>
</tr>
<tr>
<td>Consistent production of NHA data</td>
<td>NHAs are a regular/routine activity</td>
<td>NHAs are conducted regularly and data reported annually</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public data collected and compiled annually</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private data collected at least once every five years and estimated annually</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td>Minimum set of globally agreed data are produced</td>
<td>All global key indicators are produced and reported annually</td>
<td>Ordinal</td>
</tr>
<tr>
<td>Use of health accounts methodology</td>
<td>NHA methodology applied consistently</td>
<td>Data is consistent with NHA boundary definition</td>
<td>Binary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local classifications are mapped to NHA classifications</td>
<td>Binary</td>
</tr>
</tbody>
</table>

*Source: Authors' analysis.*

*Note: These indicators have not been fully tested in defining institutionalization in countries. A detailed list of 45 indicators were developed and used for some country consultations. Based on the phasing study in Appendix D2 of the main text and country consultation, the indicators were derived as key indicators to measure institutionalization.*

11. The 12 indicators (along with criteria) can be used to measure both existing levels of NHA institutionalization and the degree to which NHA institutionalization activities will help countries to move along the institutionalization path. The ordinal indicators can be assessed on a scale of 1–4. A score greater than two can be converted to 1 on the binary scale. A cross-country comparison can be made based on aggregate country scores. Countries are ranked as follows:

<table>
<thead>
<tr>
<th>Score</th>
<th>NHA Institutionalization Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>9–12 and all four criteria met</td>
<td>Institutionalized</td>
</tr>
<tr>
<td>6–8 and any 3 criteria met</td>
<td>Almost institutionalized</td>
</tr>
<tr>
<td>4–7 and at least 1 criterion met</td>
<td>Insufficient progress toward institutionalization</td>
</tr>
<tr>
<td>0–3 and no criterion met</td>
<td>Little or no prior experience with NHA production</td>
</tr>
</tbody>
</table>
III. Constraints to and Strategies for NHA Institutionalization

12. **Strengthening institutions, systems and processes are crucial for institutionalization.** Extensive consultation have helped to examine the constraints faced by countries and an assessment of the challenges have emphasized the value of establishing the appropriate arrangements (institutional and organizational), systems (including human and financial resources), and processes (including tools for data collection, analysis, and interpretation) for institutionalizing NHA.

13. **Several reasons for the slow progress toward institutionalization have been put forward.** These factors can be organized into seven core dimensions, which in turn can be used to define the framework for NHA institutionalization:

   - **Environment and governance structure.** Creating an official mandate or decree to ensure that NHA production develops under favorable conditions. Institutional arrangements and coordination within and between internal and external stakeholders is also necessary.
   - **Human and financial resources.** Developing adequate human capacity and financial resources for routine NHA production and use.
   - **Data collection.** Ensuring that methods for NHA data collection are standardized and that data are accessible and comprehensive.
   - **Data management.** Establishing means of storing and accessing NHA data in a user-friendly format.
   - **Data quality.** Ensuring that information is timely, consistent, and reliable; and that data coverage is comprehensive and disaggregated. Data should be validated, estimated, and analyzed consistently.
   - **Information products.** Defining core indicators so that countries produce data that are specific to their needs and that meet minimum global requirements.
   - **Dissemination and use of NHA data.** Ensuring that NHA data are readily available and published, and are used to inform policy and decision making.

14. Country constraints toward NHA institutionalization can be assessed along each of these seven core dimensions using a country assessment tool. Institutionalization will be achieved when countries carry out annual assessments; improve processes, capacity, and systems where the constraints exist under each of the seven core dimensions; expand to build new systems; and, finally, integrate all processes as part of a regular system of data production and use.
IV. Strategic Actions Required at the Country, Regional, and International Levels

15. Developing countries and development partners are keen to improve data on financial resources in health in order to identify gaps and provide funding in areas where the need is most urgent. Some of the main actions required at country, regional and international levels to support the institutionalization process are now presented.

Country Level

16. NHA institutionalization can be facilitated if national players adhere to the following actions:

- **Mandate long-term commitment to produce and use NHA.** Consider issuing a national mandate for the production of health expenditure information, using internationally accepted methodologies.
- **Harmonize national efforts.** Reconcile the interests of both government and nongovernment actors through an NHA steering committee or similar mechanism and find the institutional home for NHA.
- **Ensure that adequate human and financial resources are available.**
- **Fund routine production and use of NHA, not one-time exercises.** Locate areas where gaps in financing persist and where resources can be put to optimal use. Also support the design of policies that can meet future needs.
- **Introduce incremental approach towards producing the data.** Prioritize a list of key indicators that should be produced annually to advance important initiatives. Develop gradual capacity to build NHA matrices.
- **Introduce cost-reducing mechanisms.** Ensure sustained process to build capacity and reduce costs; reduce dependence on external consultants; integrate production in the framework of HIS and the national statistical system; and introduce user friendly tools and training for data collection, management, and analysis.
- **Disseminate and use NHA data.** Link NHA data to regular budgeting and accountability processes. Improve data analysis with training modules and tools for policy makers. Formulate stronger dissemination strategies and share NHA data using websites, a variety of media outlets, newsletters, policy briefs, reports, seminars, and workshops.
- **Follow a systematic process of assessment, planning, and implementation.** Assess constraints along the seven key dimensions and create work plans outlining strategies and action steps to overcome them. Then, implement those strategies in a phased manner. The plan needs to be made long term, with strategies updated on a rolling basis.
Regional Level

17. To encourage NHA institutionalization among its members, regional agencies may wish to support the following strategies:

- **Provide a platform for countries to discuss institutionalization experiences.** Discuss the challenges that countries face and the strategies that have been effective in countries that have successfully institutionalized.
- **Act as hubs of best practices and repositories of knowledge.** Assist member countries in conducting country assessments and developing implementation plans for institutionalization.
- **Broaden the focus of NHA networks from “NHA only” technical discussions to more policy related ones.** Expand scope beyond just NHA, even beyond purely financial data. Integrate NHA data with broader HIS and statistical systems.
- **Focus on higher-level policy makers and not just technocrats.** Sensitize policy makers in ministries of health, finance, and planning on the importance and contribution of NHA to evidence-based policy making.
- **Revisit mode and scope of training needs.** Training should be focused and separated for producers and users of data, as well as for countries at different levels of institutionalization.
- **Find innovative funding mechanisms for regional cooperation.** Link NHA to disease-specific studies, or those related to health-system strengthening to motivate funding. Encourage public–private partnerships and collaboration with a host of different actors that find NHA information useful for alleviating resource constraints.
- **Broaden country ownership of networks to sustain and support NHA activities.** Be transparent and accountable to participating countries and involve them in all decisions. With country-ownership—a prerequisite for institutionalization—the onus can fall on countries to both govern and finance the network themselves.
- **Improve accountability mechanisms through invoking country participation and transparency.** Periodical newsletters and policy/methodological briefs released by the network are one means of building awareness of NHA work among member countries and global partners. The matter of structure, role, financing, and governance of networks is one that needs to be decided jointly by countries and development partners.
International Level

18. The continued financial and technical support of the international community has helped some of the 130 countries produce one or more rounds of NHA. While only 11 developing countries have institutionalized NHA, to achieve their ambitious goals, development partners need to play a larger and stronger role, as follows:

Commit long-term to NHA institutionalization. Target support to ensure eventual country ownership of NHA and the necessary concomitant domestic financing.

Introduce supply-side conditions and incentives to promote NHA institutionalization. A resolution or agreement among countries will likely encourage them to frequently produce and report data.

Build NHA institutionalization activities as part of loans and grants for projects linked to resource tracking, HIS, HSS or health reform efforts.

Emphasize the routine production of a minimum set of health expenditure data. Building capacity (including local) to sustain production of some minimum set of data and use of that information, allow countries to reduce their dependence on external assistance.

Fund routine production of NHA, not one-time exercises. A shift is needed from a project- and round-based approach to more routine and focused support for specific areas.

Introduce cost-reducing mechanisms. Distance-learning courses and online guidelines and instructional manuals are pertinent. Increase the provision of e-tools (particularly for assessments, development of work plans, and data and policy analysis) to reduce reliance on expensive external consultants. Introducing expenditure questions in surveys such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), the World Bank’s Living Standards Measurement Study (LSMS) or other local surveys so that they are more relevant to NHA, is another cost-effective measure.

Harmonize efforts among development partners. At the country level, harmonization among partners helps avoid duplication of funding for the same activities, sustain regular data production, and provide funding only for the areas where support is needed. At the international level, harmonization is needed in resolving methodological differences to produce and report data; and to help build local capacity for institutionalization.

Build awareness of NHA use. Share experiences on using NHA data for policy making through learning and knowledge sharing forums; and through showcasing country stories regularly in print and media. Coordinate with policy makers at the national level to identify (i) their potential demand and uses for NHA, and (ii) how NHA can be used in parallel with other resource-tracking tools, including PERs and MTEFs. Introduce training programs for policy makers.
V. The Goal and Phasing Strategy for Institutionalization of NHAs

19. **As of 2010, 41 countries have institutionalized NHA.** OECD countries have rapidly adopted health accounts, but progress has been slow in non-OECD countries.

20. While there is no single explanation for why particular countries have been more successful than others, findings indicate that utility of NHA to a country is the most important factor in whether a country institutionalizes. Government capacity to produce and use NHA is also significant in predicting institutionalization.

21. Once these initial preconditions are met, various elements—the NHA production record (based on political will and the government commitment to routinely produce health accounts information), development partner commitment, overall governance framework, availability of financial resources to produce and use NHA, and government investments in health—have a considerable impact. Figure 2 lists these factors in order of their importance. Analysis of these factors is used for proposing a phasing strategy to ensure that the goal set below is achieved.

![Figure 2. Factors Influencing Institutionalization](image)

Source: Authors’ analysis.

22. The goal is to ensure that 100 have institutionalized NHA by 2020 and 150 countries will have produced NHA at least once. These numbers represent a critical mass, and by achieving them the tipping point toward NHA institutionalization may be reached (Figure 3). Achieving this tipping point requires that (i) 59 more countries institutionalize (on top of the 41 countries already institutionalized as of 2010); and (ii) 20 more countries start producing NHA (in addition to the 130 countries that have produced NHA at least once).
23. **Phasing Strategy.** The phasing strategy proposes that four distinct cohorts of candidate countries enter institutionalization mode during 2011–2015 at different stages of institutionalization. Out of 107 countries identified as potential countries under the various stages of institutionalization, it is assumed that 59 will be able to institutionalize by 2020. More countries may express interest and join during the decade. It is likely that after gaining some momentum in NHA institutionalization, countries that join toward the end of 2020 will continue with NHA institutionalization through the next decade (Figure 3).

![Figure 3. Institutionalization Goals](image)

Source: Authors’ analysis.

24. **Pathway to Institutionalization.** Countries have been grouped by where they stand in terms of their potential to institutionalize on the basis not only of their production record but also their governance frameworks and levels of institutional capacity. The key is for development partners to seek willingness and commitment of countries, out of a pool of candidate countries, prior to supporting their NHA institutionalization efforts. The framework that emerges from this analysis is useful for guiding both future country aspirations toward institutionalization and support from the international community.

**VI. Estimate of Resources Needed**

25. **NHA produced regularly costs less than NHA undertaken ad hoc.** The costing survey generated results from 45 countries, revealing that countries in the more advanced stages of institutionalization incur lower production expenses than countries which have made insufficient progress. The average annual costs for OECD countries that are institutionalized are US$ 89,000 (ranging from US$ 9,400 to US$ 180,000); for non-OECD countries that are institutionalized, US$ 78,000
(ranging from US$ 42,000 to US$ 155,000); for countries almost institutionalized, US$ 112,000 (ranging from US$ 23,000 to US$ 270,000); and for those which have made insufficient progress, US$ 210,000 (ranging from US$ 20,000 to US$ 700,000). Median costs for these groups are US$ 57,000, US$ 66,500, US$ 90,000, and US$ 150,000, respectively (Figure 4).

**Figure 4. Average Costs of Production and Breakdown of Expenses (US$)**

Source: Authors’ analysis.

Stages of institutionalization: I-OECD = OECD institutionalized; I-Non-OECD = Non-OECD institutionalized; II = Almost institutionalized; III = Insufficient progress toward institutionalization.

26. **Consultant fees and survey costs are major cost drivers in non-institutionalized non-OECD countries.** The cost drivers include staff salaries, consultant fees, training, office space and equipment, information technology, and survey production and dissemination (Figure 4). Countries with insufficient progress toward institutionalization (in the third and fourth stages) require three times as many staff and consultants (international and local) as non-OECD countries that are institutionalized. As Figure 4 illustrates, this can be extremely expensive with consultant fees and surveys making up the bulk of expenses in these countries. In OECD countries, the survey costs are relatively small as the data system is quite robust. As countries institutionalize, they place less reliance on new staff, and the number of staff hours required also declines. Declining survey costs with higher levels of institutionalization is indicative of robust data systems and higher quality of information.

27. In addition to the existing production costs for countries in different stages of institutionalization, scale up efforts for institutionalization may be needed to
strengthen the seven core dimensions. Based on the experiences of World Bank pilot countries, these additional investments are expected be anywhere in the range of US$ 25,000–US$ 150,000 for first several years.

VII. Anticipated Future Costs of Institutionalization

28. In 2011 it is expected that 107 countries (excluding those countries that have already institutionalized) will be in varying stages of NHA institutionalization, ranging from “almost institutionalized” to producing NHA for the very first time. It is assumed that countries in the initial stages of NHA production will take longer to institutionalize than more experienced countries, and that some countries will be more committed to institutionalization than others. Countries will enter the “NHA institutionalization phase” in different years.

29. Further, two scenarios are used to estimate future costs: Scenario 1 is optimistic, where 76 countries are targeted and 59 will institutionalize. Scenario 2 is moderate, with 60 countries targeted and 30 institutionalizing. Countries will enter at varying stages during years 1–5.

30. In the first scenario, an estimated investment of roughly US$ 150 million may be required to institutionalize NHA over the course of 10 years. In the second scenario, the estimated cost of institutionalization over 10 years is estimated to be approximately US$ 100 million. Of these, at least 25 percent of all funds will be directed toward regional and international institutionalization activities.

31. Cost savings. The analysis finds that if countries institutionalize, the average cost of production will drop to less than half that incurred by countries that undertake NHA production in an ad hoc manner. In terms of specific high-cost items, non-OECD institutionalized countries incur consultant fees and costs related to survey production that are roughly one-third of those incurred by countries that have made insufficient progress toward institutionalization. Average costs saved per country over 10 years are approximately US$ 500,000 for countries that have made insufficient progress and US$ 100,000 for those which are almost institutionalized. For the 59 countries (26 of which are almost institutionalized, and 33 that have made insufficient progress) targeted—this amounts to savings of US$ 20 million–US$ 30 million over 10 years.

VIII. Risk Analysis and Mitigation

32. Institutionalizing health accounts in countries where NHA information is not routinely produced and used may have some risks. Levels of uncertainty are elevated in instances where local ownership is missing, consensus among
stakeholders cannot be reached, resources are scarce, NHA utility is unrecognized, and interest at all levels (if it previously existed) has started to wane.

33. It is essential that risks are monitored and minimized to reduce the probability of an event taking place that would interfere with institutionalization efforts. Risks are unavoidable but can be mediated through adequate technical (and financial) support at all stages of the institutionalization process. Based on the items addressed above, a country rated as high risk will need mitigation built into both the design and implementation processes.

Appendix 1. Consultations for Inputs into the GSAP

This document has been developed through a consultative process. Country, regional and international consultations and discussions with development partners have provided important contributions.

Core team: Charu Garg (Team Lead) Rubama Ahmed, Vaibhav Gupta, Mahesh Shukla, Mukesh Chawla (overall supervision). Ilaria Regondi assisted in the compilation of this conference volume.


International Conferences
International Health Economics Association (iHEA). Beijing, China (July 2009)
Prince Mahidol Award Conference (PMAC). Bangkok, Thailand (January 2010)

Regional Consultations
South and East Asia. Delhi, India (December 2008), Latin America. Mexico City, Mexico (January 2009), Africa. Nairobi, Kenya (April 2009), Europe and Central Asia. Yerevan, Armenia (November 2009)

Country Consultations
Ouagadougou, Burkina Faso (June 2009). Bogota, Colombia (April 2009, September 2009)
Development Partners
AusAID, DANIDA, GF, GTZ, IMF, IDB, Netherlands Development Cooperation, NORAD, OECD, SIDA, USAID, and WHO

Case Studies Completed
Ethiopia, Georgia, Guatemala, Indonesia, Madagascar, Mongolia, Nicaragua, Philippines, Rwanda, Thailand

Regional NHA Network Studies Completed
Asia Pacific National Health Accounts Network (APNAN), Eastern, Central and Southern Africa (ECSA), Euro-Asia, Middle East and Northern Africa (MENA), Network of the Americas on Health Accounts (REDACS)