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Issue Paper on

National Health Accounts – Where are we today?

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Acronyms

ADB	Asian Development Bank
APHEN	Asia Pacific Health Economic Network
Danida	Danish International Development Agency
EU	European Union
HCFA	Health Care Financing Administration
IDB	Inter-American Development Bank
ISIC	International Standard Classification of all Economic Activities
MOH	Ministry of Health
NGO	Non-governmental organisation
NHA	National health accounts
OECD	Organization for Economic Cooperation and Development
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform Project
SA	Satellite Accounts
Sida	Swedish International Development Agency
SNA	System of National Accounts
UN	United Nations
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Summary

Health care financing is an internationally recognised area of great policy importance for low and middle-income countries. National Health Accounts (NHA) is a practical and useful approach for understanding health care financing issues in low- and middle-income countries. NHA is a method for gathering national health financing and expenditure data from both the public and private health sub-sectors, including consumers. NHA tracks expenditure flows across a health system, and links the sources of funds to service providers and to ultimate uses of the funds.

The development of NHA in different parts of the world varies greatly. Many low- and middle-income countries have created NHA during the 1990s but only a few have implemented NHA as an established system. Whilst there is a wide range in terms of the level of development of NHA, there is a clear trend towards increased interest. A number of networks have been launched in recent years. WHO and other organisations receive several requests for technical and financial support from countries interested in taking up NHA work.

The methodology used varies between countries, and also to some extent between regions. In Asia, several countries have adopted the OECD SHA framework, while the majority of countries in the South East African region use the Harvard framework. Also, in Latin America the Harvard framework dominates, although a few countries have used the UN SA framework. There is still diversity between the frameworks adopted in national systems in terms of which expenditures are included and not.

Support for the creation of NHA commonly comes from the Health Ministries, Donors, UN agencies and other Multilateral agencies. This support is sometimes financial while in other cases it is only a technical supporting role.

The greatest users of NHA today are multilateral organisations and donor agencies. NHA is also being used by governments, however not to such a great extent yet. Among those countries that have institutionalised NHA we find a common feature, which is that the health ministry are users of NHA.

1 Introduction

In many countries the health care sector plays an important part of the economy by employing large numbers of people and by absorbing considerable amounts of national resources. However, there are huge differences between developed and developing countries in terms of capacities and health services provided. This is partly due to the severe resource constraints and the higher disease burden. 84 percent of the world's population live in developing countries and they account for 93 percent of the global disease burden along with only 11 percent of all health care spending (World Bank, 2000). This implies that there is an inadequate provision of health care in many developing countries. The provision of health care is one important input for health together with other factors such as clean water, sanitation and life-style, which also affect the health status of the population. Accounting of the financial inputs to health is elementary when striving to make the best use of available resources.

The changing demographic picture in developing countries in combination with a rapid urbanisation will have large implications for the delivery of health services. Health care resources are fundamental in provision of health care and for governments to use them wisely, knowledge is needed concerning the country's health care spending. This issue becomes even more critical when considering the fact that it is unlikely that health resources will be greatly increased and at the same time demands for health care will continue to grow (WHO, 1999).

Good information concerning the financing of the health care sector and the utilisation of funds builds a cornerstone for health policy development. Estimates of national health expenditures are needed for analysis of the health care sector and by compiling National Health Accounts (NHA) the possibilities of improving the health sector's performance increases. In industrialised countries, this issue has been widely acknowledged for several decades and the OECD (Organization for Economic Development and Co-operation). systematic accounting of national health expenditures is well known. However, in developing countries the situation is different – or has been until recently. During the last 5–10 years, the interest in producing health accounts in developing countries has grown. Also, methods to produce health accounts in developing countries have improved continuously.

NHA is an appropriate tool and internationally recognised for health expenditure analysis. The methodology measures total national health expenditures and is based on internationally recommended concepts and definitions. The structure of NHA is based on a flow of funds reflecting all the main functions of health care financing, i.e. resource mobilisation and allocation/purchasing and payment of care.

Box 1. What are National Health Accounts?

National Health Accounts are a set of accounts that describe all expenditure flows within the health sector, both governmental and non-governmental. In short, they describe;·

– Where does the money come from? (sources of funding)·
– Where does the money go? (uses of funds)

The aim of compiling National Health Accounts is to achieve a comprehensive and consistent synthesis of health related activities.

The health care systems and their financing in low- and middle-income countries usually differ from those in the higher income nations. The financing of the health care system is commonly more diversified with multiple sources of funding. Also, the problems they face differ from higher income nations and priority setting is harder. Another distinguished feature is that low- and middle-income countries commonly experience more significant and rapid changes within their health systems.

The aim with this report is to describe how far the work on NHA has come in the world today.

2 Background

2.1 History of NHA

The interest for health accounting can be traced several decades back. Already in 1960 Abel-Smith with support of the World Health Organization (WHO) carried out the first major national comparative studies of health expenditures in Ceylon (now Sri Lanka) and Chile. He followed up with a study of 14 developing countries: five from the African Region, five from the Americas, two from the Eastern Mediterranean Region, and two from the Western Pacific Region. Further country specific work took place during the 1970s and 1980s with the support of WHO and others such as e.g. United States Agency for International Development (USAID), the World Bank (WB) and Pan American Health Organisation (PAHO). Other researchers and governments performed yet other studies of health expenditures. It became apparent that collecting national health expenditures were useful for several purposes. However, comparative analysis between countries proved to be difficult since different methods of compiling NHA often were used. During the end of the 1980s and the beginning of the 1990s it started to become more and more evident that there was a need for standardisation of the methodologies used for estimating national health expenditures. Comparisons between countries had become almost impossible to do.

Since the early 1990s the interest regarding health accounts and the production of health accounts have grown tremendously around the world. Its usefulness in e.g. health sector reform work has become evident, which has encouraged large international organisations, such as WHO, WB and several donor agencies, to become more involved in the area of health accounting.

The measurement and description of health care expenditures has become demanded information by policy makers in developed countries. In developing countries, on the other hand, good information regarding the financing of the health sector and the use of funds have not been either demanded or supplied to such a high extent. This picture is however slowly changing as more and more countries become involved in creating national health accounts.

After the World Health Report 2000 "Health Systems: Improving Performance" (WHO, 2000), the interest for measuring health systems' performance have grown rapidly. The report pointed out the importance of having access to good information and correct data for describing national health systems. It pointed out that National Health Accounts is such a tool.

2.2 What are health care expenditures?

Compiling National Health Accounts, i.e. counting up total health care expenditures, requires definitions of types of expenditures. First, what are expenditures on health or what counts as health care? This question may seem simple, but when creating NHA a precise definition is needed. It becomes even more important in an international perspective as for making international comparisons shared definitions are an absolute requirement. This is also one of the main reasons for countries to agree on using a common methodology. There are today variations between countries of what is included in the definition of health expenditures. However, these variations have tended to diminish lately, especial-

ly since more and more countries start to use the same methods for health accounting. Health expenditures are commonly defined as all expenditures for prevention, promotion, rehabilitation, and care; population activities; nutrition; and emergency programs for the specific objective of improving or maintaining health. Health includes both the health of individuals as well as of populations.

Box 2. What are health care expenditures?

The approach taken in many countries and one which facilitates international comparisons is to define "health expenditures" as any type of expenditure for which the primary objective is to improve or prevent the deterioration of health status.

NHA is based on a functional definition of health. Expenditures are included in the NHA according to the function or type of activity being performed and not based on the provider of that activity. Expenditures are health expenditures regardless of whether the entity carrying out or paying for the activity has health as its primary purpose e.g. the Ministry of Defence. Health expenditure can include spending for curative services, prevention, promotion, rehabilitation, and care, as well as population activities as long as these are carried out with the primary purpose of health improvement.

2.3 Why create National Health Accounts?

Health care resources are fundamental in health care provision. To provide health care a substantial number of health care resources need to be brought together to deliver a wide spectrum of different service outputs. The health sector is a complex sector providing a service that is an important social issue. Health care resources are scarce (just as all resources) and decisions regarding the most efficient use of these resources need to be based on good information of expenditure in the health sector. Developing NHA is an important step to make better use of health care resources and essential for measuring the performance of the health care system. To reach and measure policy goals in the health sector, such as equity, the information obtained by creating national health accounts is needed. Evidence on health financing can contribute to improved performance both by strengthening the health care policies to improve health systems functioning as well as in measurement of the outcomes of the health system as recognised by WHO's year 2000 World Health Report (WHO, 2000).

In national health accounts complete information on the health system's expenditure is provided. Every dollar, krona or schilling spent on health care is recorded and tracked from the source of financer to the use of it, in both governmental and non-governmental sectors. With this information weaknesses as well as opportunities within the health system is revealed and the potentials for identifying possibilities for improvement in the performance of the health system increases, e.g. the country's scope for succeeding with health care reforms grows (WHO, 1999). Lack of knowledge about resources and the use of resources create a health sector that is difficult to run and showing poor performance. In a well functioning health system, planning and coordination of available resources takes an integral part. For this process accurate information about available resources is needed. Whatever a country's income level, there exist efficient ways to allocate health care resources allowing the health system to function at its best.

Box 3. What can NHAs reveal?

How much does a country spend on health care? Who is paying and for what services? How much is allocated to priority health programs or populations? Who are the key providers? The answers to these types of questions are revealed through national health accounts.

In conclusion, NHA show where the money comes from and where the money goes. This information can be used to identify areas of concern and specific problems in the health sector, e.g. Mexico has used NHA to identify equity problems.

It is important to point out that creating national health accounts is not the answer to all our problems in the health sector. National health accounts only provide the information of how health care resources are being used – it is up to each country to use this information wisely. Also it needs to be pointed out that if national health accounts never have been developed before it may require large efforts in its early phase. However, once the process can been integrated into the daily work of e.g. the Ministry of Health, time used for creating national health accounts decreases substantially. The information base provided by consistent collection of data and creation of NHA strengthen the capacity to deal with policy issues. Attempts to reform the health care system become easier with precise information available.

3 Methods

3.1 Different methods of health accounting

There exist different methods of measurement and description of health expenditures. It is mainly two approaches to health expenditure estimation that has been used widely, namely National Health Accounts (NHA) and System of National Accounts (SNA). They developed with different purposes and consequently differ in a number of ways (see Ravindra et al., 1997 for a good description of SNA and NHA). The SNA is a standardised system of statistical analysis, with international cross-comparability and internal consistency. The SNA is the responsibility of the official national statistical agencies in each country and the United Nations (UN). The NHA approach on the other hand is a more recent development, which more or less developed within the health sector of countries, specifically constructed to fill their perceived needs of data on health expenditures. The approach is not yet standardised, even if the development during the last few years certainly has been working towards this end. The definitions of health care and what kind of expenditures is included differ slightly between countries, since the NHA methodology of accounting often differs between countries. The responsibility of compiling NHA rests with e.g. individual research teams, the health ministry, and is on some occasions not officially supported.

An important difference between SNA and NHA are that SNA shows links between the health sector and the macro-economy while NHAs only describe the flows of resources within the health sector. SNA also makes a distinction between capital and recurrent expenditures while NHA does not. In SNAs' 1993 revision, the method allows for the creation of satellite accounts linked to the central framework (United Nations, 1993). These Satellite Accounts (SA) share the same objectives as NHAs, as they are designed to support analysis of expenditures on a specific purpose. However in contrast to NHAs, SAs must retain an explicit linkage to the structures and quantities within the central framework.

A number of expenditure accounting systems for health and health care have been developed and made increasingly compatible over time. A NHA system with worldwide influence is the one maintained by the United States Health Care Financing Administration (HCFA). Its NHA system has influenced many low- and middle income countries. Except for the US NHAs, the one developed by OECD is the most influential one. The OECD has devoted considerable resources to the development and refinement of standardised systems for measuring health expenditures, the utilisation of health care services, and to a lesser degree, health outcomes (OECD, 1985, 1987; Poullier, 1989, OECD, 2000). The OECD's System of National Health Accounts (SHA) is the most successful system when it comes to developing standardised estimates. The SHA method to health accounting can be descried as something in between NHA matrices and SAs. OECD receives annual reports from its member countries. Many OECD members compile somewhat different or more disaggregated expendi-

ture accounts for their own sake, although recently several have made an effort to create NHA in a similar manor.[1]

Box 4. System of Health Accounts – SHA

The System of Health Accounts is organised around a three basic questions for the recording of health expenditure. They focus on health care by function, health care services provider industries and sources of funding health care. The presentation is done in sets of inter-linked tables, each showing different aspects of health care services.

In the mid 1990s Dan Waldo (1996) and Peter Berman (1997) and others proposed a simple matrix system of NHA building on the framework of the OECD, WB, and national systems within countries where the pluralistic system of the United States played an important role. The aim of this NHA methodology, known as the "Harvard method", was to develop a methodology that suited low- and middle-income countries better than the methods already available. The strength of the method was its straightforwardness and simplicity. Needless to say, methodology from industrialised countries provides important knowledge for developing countries. There was at time of the development of the Harvard method a need in low- and middle income countries for a method of creating NHA that met their needs.

The Harvard method consists of built matrices, which answer to the question of "who pay, how much and for what". The method aims to make explicit analysis of sources of financing, financing intermediaries, and to classify the uses of funds. The Harvard method has since 1997 been introduced and used by several countries in different parts of the world.

Box 5. National Health Accounts the Harvard method

The NHA according to the Harvard method relies on a matrix approach for presentation and focuses on the flow of funds. In one set of accounts health care expenditures are classified by type of provider and by who pays. Matrices can also be constructed to display e.g. geographic region or patient characteristics (gender, position in the income distribution, etc.).

3.2 Methods used

The approximately 60 low- and middle-income countries that have created or are currently creating NHA have used the different approaches (see Appendix I for details on specific countries). The most common method used is what is called the "Harvard approach" to health accounting (NHA methodology), which 63 percent of the countries have used. The OECD System of Health Accounts (SHA) has been used by 31 percent of the countries. And finally, a few countries have used the UN Satellite Accounts to develop health accounts, 6 percent.

[1] The OECD has created an impressive database that is widely used. The OECD Health Data is an interactive database comprising data on a great number of key aspects of the health care systems in the 29 OECD member countries. A practical User's Guide, which is available in English, French, German and Spanish, is also provided.

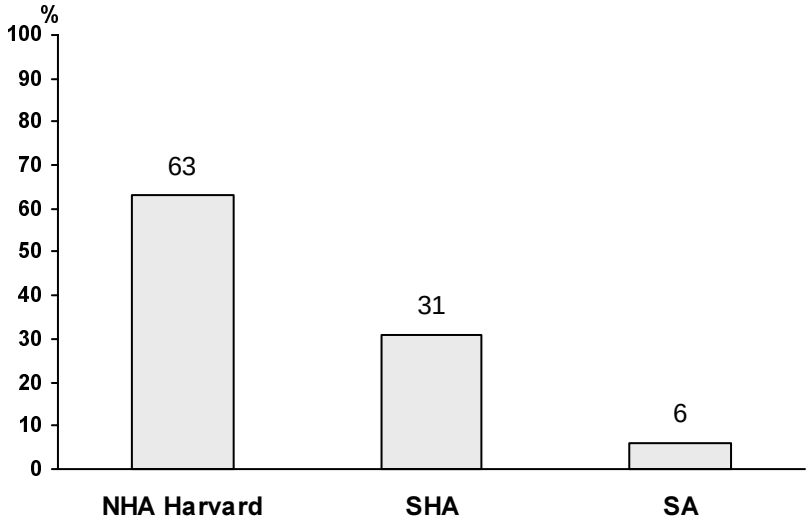

Diagram 1. Methods used by low- and middle-income countries.

There are differences between world regions when it comes to approaches used for health accounting. In Africa, the most common method is the "Harvard approach". In Asia, on the other hand several countries have used the OECD System of Health Accounts for health accounting. Some Asian countries have also used the "Harvard approach". In Latin America the "Harvard approach" has been used, but a few countries have used the UN Satellite Accounts for health accounting. It is possible that a large group of countries within the MERCOSUR (Southern Cone Common Market) network will use the OECD System of Health Accounts when developing health accounts in the future. In the Middle East, the most common approach so far has been "the Harvard approach".

Why one country decides to use a specific approach and another country decides to use another method seem to depend on several factors. One important determinant is whom the initiative taker is. If the initiative is offered by a donor to develop NHA, the country is often offered either technical assistance from international experts or offered to enter a network where technical assistance is provided at workshops etc (or both). It is then the method known to (or preferred by) the technical expert, or used in the network, that is adopted by the country for health accounting. Another factor influencing the approach used is of course the institutional capabilities in countries and individual preferences among those involved in the process of health accounting.

For further details on health accounting methods used (or in some cases planning to be used) in different countries, see the map provided in Appendix II.

4 Producers and users

4.1 Producers of NHA

There seem to be a great diversity between countries in terms of whom the initiative takers of compiling NHA are. The most common agencies taking the initiative to create NHA can be divided into the following categories; the countries own ministries (e.g. the Ministry of Health); non-governmental local organisations; research agencies (public or private); Multilateral organisation; donor agencies.

Also variations (and similarities) exist between countries regarding which agencies being responsible for commissioning and as well as for the development of health accounts. The most common institution to be responsible for NHA is the Ministry of Health, however this is not the case everywhere. NHA development in different countries differs mainly due to differences in institutional capacities but also depending on the fact that NHA were created for different reasons. There is no unique path to establish NHA. Where the institutional responsibility rests will naturally differ between countries. In some countries NHA has been developed as part of another project, such as estimating expenditures on HIV/AIDS, and consequently the responsibility for the health accounts rests with the research team. In other countries, NHA was created for its own purposes with the aim to build the capacity within the country for creating NHA. Where this is the case, the responsibility of creating NHA commonly rests within the Ministry of Health (or related ministries). Yet in other countries, perhaps the process of starting to develop NHA was initiated by a Multilateral- and or Bilateral organisation, which perhaps has lead to that the responsibility for NHA rests outside the government.

When it comes to the actual production of NHA, the Ministry of Health is not as likely to be producing it as commissioning others to create the accounts. However, in many countries it is the Planning units within the ministry that are responsible for the production of NHA and for putting a NHA team together. The team then commonly consists of staff from Ministry of Health, but also staff from other ministries e.g. Ministry of Finance. Apart from the ministries technical production of NHA commonly involves public sector research agencies, National Statistical offices and universities. These institutional variations between countries in the world seem to reflect partly on differences in capacity of national agencies and partly on who the initiative-takers are.

4.2 Who are the users of NHA?

The main users of NHA today are multilateral organisations and donor agencies. Donors themselves have become big users of NHA and multilateral organisations such as the WB use NHA on a regular basis. These organisations' need for data regarding health sector spending is great and has been so for many years. The most long-term user is perhaps the WB who has used (and required) data on health sector spending for several decades. Data is being used for in-country analysis as well as international comparisons between countries and world regions. For donors, the greatest use of NHA seems to be in-country analysis of health sector spending.

Governments also use NHA for internal decision and policy making as well as for budgeting purposes. However individual countries do not use NHA to such a great extent yet. There are of course great variations between countries both regarding actually using the data as well as to what extent NHA is being used. A few countries are using their NHA data regularly for planning, policy-making and for problem identification. Examples of countries that have used and are using NHA regularly for decision-making, planning etc in the health sector are Bolivia and Mexico. Why such large differences exist between countries seem to depend on differences in the knowledge of how and for what the data can be used. In some cases the government are even unaware of that NHA has been created and are available.

Other users of NHA are e.g. companies entering the market e.g. pharmaceutical market or another market related to the health care market. There is no information available on the secondary users of NHA.

There are examples from different parts of the world of countries that have used their NHA. There are some good examples of countries in Latin America, which are using their NHA. The Bolivian Health ministry is using information obtained in their NHA on a regular basis when making decisions on the provision and financing of health care. In Guatemala, where the Peace Agreements included the reallocation of resources to improve health conditions for the poor, monitoring and assessments were made through the NHA. In Ecuador, NHA was used as an element for resource allocations. In Colombia the transference analysis through the household expenditure and the use of health services by institution allowed to define some of the reform changes. In Mexico NHA was used to identify that the structure of the health system was inequitable and resources could be allocated differently.

In Africa, where NHA perhaps not yet is so established there are examples of countries that have used their results. In Malawi, NHA was (and is) used for resource allocation and contractual agreements with NGO's. Also in Malawi, the results obtained in NHA revealed the need for introducing cost-sharing mechanisms. In South Africa NHA has been used to identify issues of equity and financial burdens. Egypt has used their NHA in a similar manner. In Morocco, NHA has been used for studying maternal health and child health care expenditures. In Rwanda a special feature of the NHA project is the adaptation of the NHA framework to study specific expenditures on HIV/AIDS. One finding from the household survey carried out as part of the NHA project was that HIV seriously impairs the ability of households to meet basic needs, such as paying for food, housing, education and clothing.

In summary one may conclude that in general NHA is not being used to the extent it should be or deserves to be by the countries themselves. It is likely in the future that when NHA gets more established more governments will understand its potentials.

4.3 Institutionalisation

A number of low- and middle income countries have institutionalised the development of NHA (for details on specific countries see Appendix III). Perhaps, the earliest to realise the importance of developing NHA on a regular basis were countries in the Latin America region and in the Asia-Pacific region. Also coun-

tries in Africa and Middle East have realised the importance of developing NHA on regular basis.

From those countries that have institutionalised NHA we learn the importance of having a health ministry that is interested in using the NHA and aware of its potentials. A political will to produce and use NHA can be found in several of the countries that have institutionalised NHA. Incorporating the production of NHA into the Health Sector Reform agenda can strengthen institutional capacity. This seems to have strengthened both the process of institutionalisation and contributed to capacity building in many countries. Also, since the turnover of human resources for NHA teams in some countries is high, it appears important to have staff at the ministry of health involved in the actual development of NHA (not only steering the project). Training is an important component of maintaining the capacity for developing NHA within the country. However, the most important subject in the institutionalisation process is the use of NHA. If the government is using it, it is almost always being institutionalised.

4.4 Financing

Several countries have received external funding for taking up the activity of compiling NHA. It is mainly technical expertise to compile NHA that has been financed. Financing of the provision of technical assistance has been made by donor agencies and multilateral organisations. The donor, who so far has contributed the most to in-country activities, is USAID. USAID has financed technical assistance in several countries in the Latin America and Caribbean region, Middle East and Africa (for further details on country specific financing activities see the Appendix). In Africa the largest contributors to in-country activities as well as regional workshops have been USAID and Sida (Swedish International Development Agency). Other contributors to NHA activities in Africa have been WB, WHO, Danida (Danish International Development Agency) and EU (European Union).

In Latin America and the Caribbean USAID has financed technical assistance in several countries as well as regional workshops. Another partner very much involved in NHA activities in the region is PAHO. Just as in Africa the WB has been active in financing NHA activities. Another organisation, which has contracted for NHA activities with countries as part of their loans, is IDB (Inter-American Development Bank).

In Asia surprisingly few donors have contributed to the compilation of NHA. Several countries have made large efforts without or with limited external technical and financial assistance. However WB and ADB (Asian Development Bank) have financed some countries NHA activities.

The technical assistance and workshops is just one part of NHA activities. The largest part has usually been financed internally by the countries themselves. In some cases technical assistance has been provided and the rest of the activities has been financed with own funds.

There are great variations between countries of how much the development of NHA has cost. In some countries NHA have been developed with small means while in other countries several hundred thousands of dollars have been made available to develop the accounts. These differences do to some extent reflect on

differences in capacities between countries. However in some cases it is merely a reflection of the input of donor money.

4.5 Networks

There are a number of networks that have been developed during the last few years in different parts of the world. Today there are networks in Latin America and the Caribbean, East and Southern Africa, Middle East and North Africa and in Asia. These networks are usually formed between countries in the same region, e.g. as a part of already established organisations or networks such as the Asia Pacific Health Economic Network (APHEN) who has a NHA group.

Table 2. Regional networks

Area	Year it was launched	Member countries	Sponsors
Latin American and Caribbean	1997	Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua and Peru.	USAID PAHO
East and Southern Africa	1999	Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe	Sida USAID WB
Middle East and Northern Africa	1999	Djibouti, Egypt, Iran, Jordan, Lebanon, Morocco, Tunisia, Yemen	USAID WB WHO
Asia (within APHEN)[1]	1998	Australia, Bangladesh, China, Hong Kong SAR, India, Indonesia, Korea, Malaysia, Maldives, Nepal, The Philippines, Singapore, Sri Lanka, Taiwan, Thailand	
Middle East	2001	Bahrain, Oman, Kuwait, Palestine, Qatar, Saudi Arabia, Sudan, Syria	USAID

[1] Asia Pacific Health Economics Network

The first network to form is the one in Latin America, called the "Caribbean Initiative", which was formed in 1997 by a number of countries. In Africa the Eastern-Southern Africa network on NHA was formed in 1999. In the Middle East and Northern Africa another network was formed the same year. Asia has a NHA network formed between countries in 1998. Recently a new network was initiated in the Middle East.

Creating NHA for the first time poses a challenge that may become significantly easier when individual countries come together as a group. Discussions and meetings in these networks help individual countries to overcome some of the difficulties they come across when creating NHA. The benefits of networks are several. Not only do they ease the task of creating NHA and work as a forum for

bringing up difficulties faced by the country NHA teams, but they do also bring the countries together in the sense that both formal and informal contacts are made between the countries' representatives. These contacts may in the future serve well for other purposes than creating NHA.

The goal behind NHA networks is to build capacity and sustainability in the region for national health accounting through collaboration. This opens up for a dialogue between producers of NHA not only sharing of expertise and experiences, but it also facilitates discussions regarding standardisation of classifications. Another important goal with these networks is, within the region, to encourage the use and application of NHA.

There are differences regarding how the networks have developed. Networks have been formed mainly due to two reasons; 1) Initiative taken by donor to develop NHA in a specific region 2) Initiative taken by for other purposes already established network.

These differences in how networks have been formed may reflect on the sustainability and the development of the networks.

4.6 Training and Guidance

During the last few years the interest for developing NHA has grown tremendously over the world. As a response to this, training and guidance in how to develop NHA has increased. At Harvard the International Health Systems Group, IHSG, a course on "Creating and Using National Health Accounts for Health Financing Reform" has been offered for several years. The course has been held in USA in the spring. This two-week course provides training in theory, methods, and applications of NHA relevant to planners and practitioners in low and middle-income countries. Recently an initiative has been taken by PHR with financing from USAID to hold a series of training courses in Africa "Understanding and Using National Health Accounts in Eastern and Southern Africa". The first course is scheduled to take place in early November 2001. The course duration will be between 5–10 days. The plan is that the course will be conducted at least once a year for the next four years at a different academic institution in an alternating country in the region.

A great amount of training has been going on at workshops and meetings held between countries within the networks. Training has been integrated as a natural component into their workshops and meetings. Also special regional initiatives has been taken, in e.g. Latin America, where a number of countries have been invited to take part in a few days of training in developing NHA. WHO's NHA office in Geneva has also been training country teams and giving advice on how to develop NHA.

Currently a Users Guide NHA "Producers Guide" is being developed by a group of international experts. The Producers Guide will propose a framework for middle and low-income countries providing practical guidance on how to develop NHA. It is planned to be completed in the end of 2001 and it will be produced in English, but will be translated into both Spanish and French.

The OECD manual "A System of Health Accounts" has been prepared for the OECD countries but can be used by any country that wants to create NHA using the ICHA-classifications. The manual of the System of Health Accounts

provides a standard framework for producing a set of comprehensive, consistent and internationally comparable accounts to meet the needs of public and private-sector health analysts and policy-makers. It is currently available in English and French, however it will also become available in Spanish.

Today, there is only one software available for creating NHA; "The Harvard NHA software v.1", and it was developed in 1996. The NHA software is a windows-based training and data management tool. "National Health Accounts v. 2", incorporates the new OECD ICHA classification scheme and is compatible with more advanced versions of MS Windows such as Windows 95, 98, 2000, and NT. It was developed with support from USAID through the Partnerships for Health Reform Project. The software has been used in training programs in Latin America, Africa, and the Middle East.

5 Main actors involved in NHA work today?

5.1 Worldwide

At global level or international level, a number of organisations have collaborated for a number of years in view of developing sustainable institutions for the collection, dissemination and analysis of National Health Accounts. There are three multilateral organisations that have been very much involved worldwide, WHO, PAHO and WB. Another multilateral organisation involved in NHA is the IDB.

There are a number of donor agencies that have financed NHA activities. However it is mainly two that has contributed a lot on a global level. USAID and Sida. Both of these organisations take part in international discussions and meetings making an effort to bring NHA forward.

One private organisation that has worked with NHA in almost all parts of the world is Partners for Health Reform (PHR). At Harvard University the International Health Systems Group has worked with the development and application of NHAs internationally.

Finally the OECD has been involved in the development of health accounts for over 30 years.

5.2 …and what do they do?

These institutions play different roles in worldwide activities. Nevertheless they play an important role. All involved partners view National Health Accounts as a vital tool for health policy making and health sector performance monitoring. In short, one can summarize their activities to evolve around the following: Development of Health Accounting methodology, Technical Assistance, Regional Workshops. Some of the institutions work directly with these activities while some give support to such activities.

Several of the involved partners work together in order to enhance the creation and use of NHA. One example of such activity is the "Shared Agenda Initiative". It is a Coordinated Action Plan for Development of National Health Accounts in Latin America and the Caribbean. Four funding and technical agencies working in Latin America and the Caribbean will work in a coordinated effort to produce NHA for all countries in the region within 3 years. The agencies are IDB, PAHO, USAID, and the WB.

Another joint project is the development of an NHA Producers' Guide for low and middle-income countries, now in preparation and expected to be finished in the end of 2001. Co-funded by the WB, WHO, and USAID, the Producers' Guide is being jointly prepared with a team from Harvard's School of Public Health. The Producers' Guide is a response to several countries demands of understanding "how to get started" on NHA, and a response to the multiplicity of approaches to generating NHA data that have emerged from decades of parallel developmental work across countries.

5.3 Regional and national actors

At regional and national level there are many public and private actors that play an important role for the development of NHA for groups of countries as well as for single countries. First of all we have the WHO local offices, which so far have been involved to a minor extent, but their roles could preferably grow in the future. Also there are universities and several research agencies that have played a role for the development in their region, e.g. the Health Economic Unit at Cape Town University, who has contributed to the development of NHA in many of the African countries. Trading organisations and economic networks have contributed to the expansion of NHA in large regions of the world e.g. MERCOSUR in Latin America and APHEN in Asia. Moreover, there are a number of private consultants that have been working with NHA giving technical assistance and advice to country teams.

5.4 Recent developments

During the last few years we have seen a growing interest for NHA among multilateral organisations. This has lead to an increased international co-operation between involved partners, such as the WB, WHO, PAHO, USAID, OECD, Sida and others. The co-operation has evolved around such issues as methodological development of NHA and joint regional initiatives in different parts of the world. The production of the "Producers Guide" is one example of co-operation between several multilateral organisations. In the fall of 2000 Sida and WHO arranged an international seminar on National Health Accounts in Sweden. "The Malmö Meeting", which was the first of its kind, brought together interested partners to discuss the present situation regarding NHA and the way forward. The meeting was important in the sense that all the major actors were present and a number of important issues on NHA could be raised.

Another development during the last few years is the WHO Geneva office working entirely with National Health Accounts. The office supports member states with: methodological material, run courses and hold meetings. Also at WHO an impressive NHA database is being built. For some countries the data range from the 1970s up until today.

When mentioning recent developments we need to bring up the networks that have been formed for health accounting. The development has to some extent been enhanced by that a number of NHA-networks have been formed. The first one was formed in Latin America in 1997 and since then networks in Africa, Middle East and Asia have been formed.

6 Conclusions

Creating National Health Accounts have become an increasingly widespread among low- and middle- income countries during the last few years. Ten years ago National Health Accounts was available only for a few countries, and commonly interests outside the countries had created the accounts often with the purpose of analysing the health sector in line with their own interests. Today, the situation is quite different. Approximately one third of all low- and middle-income countries have produced or are under the process of producing National Health Accounts. This development can very much be attributed to the efforts made by the multilateral organisations WB and World Health Organisation along with the efforts taken by donors, e.g. USAID and Sida, to fund these efforts. Without these efforts, National Health Accounts would never be as widespread as it is.

However even if we have come far in terms of many countries developing accounts, many challenges still lies ahead. First of all, the use of National Health Accounts needs to be enhanced. Creating them is not enough, they need to be used as the useful piece of information they are. Only when a government fully knows and understands what National Health Accounts can be used for, they can begin to reflect on what to do with the information. Information is essential, but does not imply that once a government has it, they will actually use it wisely. Part of the problem is that the link between NHA and policy making is not very clear. A general observation is that once the link between NHA and policy making becomes clear, the users of NHA will increase. Second, countries need to use the same methodology in order to make comparisons possible. Much has been done in this area and once a handbook in how to produce NHA ("Producers Guide") is published, differences in health accounting approaches will hopefully diminish. Third, the development and use of National Health Accounts needs to be institutionalised in order to sustain the development so far. There may be institutional aspects to consider, e.g. differences in the ability of a country to adapt new sources of information, which very much depends on the capacity of its people and its institutions. Capacity-building includes not only how to build National Health Accounts, but also how to implement them as a source of information used on a daily basis. There is a need to find a simple but effective way of doing this. A fundamental purpose of capacity-building for National Health Accounts should be to enhance the capability to assess and focus on the essential questions related to policy options and of needs as perceived by the country concerned.

The majority of low- and middle-income countries lack the sufficient knowledge of how to create NHA. As an increasing number of countries are gaining interest in NHA, the demand for workshops and courses will increase. So far, courses and workshops have often focused on the actual creation of NHA, which also has been demanded and still is. However as more and more countries have created NHA, it is likely in the future that courses and workshops regarding the use of NHA will be of greater importance to provide. As concluded at the international NHA-meeting in Malmö, the demand for NHA can be stimulated in several ways, e.g. by seminars and courses involving policy makers, giving examples on how NHA can be used. Donors play an important role, advocating for the use of NHA and above all use it in their own analyses.

The networks will play an important part in the future development of NHA, both in terms of decreasing the heterogeneity in methods used for health accounting and for advocating the use of NHA. Organised efforts from networks regarding the link between NHA and health policy and systems research can enable countries to optimise the use of scarce resources for health care. Ongoing health reforms add to the need for attention to this research area.

In the future, the encouragement given from major multilateral organisations and donors both to individual countries and to networks will very much lead the way for health accounting. One important issue will be support of the use of health accounts. The development we have seen the last few years in terms of increased co-operation between multilateral- and donor-organisations has very much contributed to the development of health accounting in a positive way. Such well harmonised and organised efforts provide good prospects for the future.

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Organisations who has contributed with information to this report
WHO, PAHO, USAID, PHR, Harvard (HSPH), IDB, WB, Sida, HCFA, OECD

Organisations with extensive experience of and interest in NHA

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PHR	Ibrahim Shehata
Sida	Pär Eriksson
USAID	Karen Cavanaugh
WB	John Langenbrunner
WHO	Jean-Pierre Poullier

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Appendix

Health Accounts – The latest status in low- and middle income countries

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Sub Saharan Africa									
Botswana	NHA methodology	NORAD	NORAD	MoH		?	Have attended two meetings in the Eastern-Southern Africa Network	Have produced health expenditure data	?
Cameroon	NHA methodology	USAID?	WB						?
Eritrea	NHA methodology	USAID	Probably PHR		MoH			Have just started and no estimates are ready yet	
Ethiopia	NHA methodology	USAID	PHR	MoH	MoH		Eastern-Southern Africa Network	Interested in looking at NHA on regional level	95/96
Kenya	NHA methodology	USAID, Danida	PHR	MoH, Planning Unit	MoH		Eastern-Southern Africa Network		1995
Mada-gascar		USAID are interested	Maybe PHR					Are interested in starting to build NHA	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Malawi	NHA methodology	Sida, USAID EU	PHR	MoHP, Planning Unit	MoHP, Planning Unit	It is a continous project, but not yet institutiona-lised	Eastern-Southern Africa Network		1998
Mali								Has contacted WHO about help to produce NHA	
Mozambique	Not really NHA methodology (only a health exp. Review)	USAID	MSH, Management Sciences for Health	MoH	MOH	To early to say anything about institutionalisation	Eastern-Southern Africa Network	Have only done a health expenditure review	1997
Namibia								Namibia has recently declaired an interest in starting to work on NHA -contacted WHO	
Nigeria								Are about to start	
Rwanda	NHA methodology	USAID	PHR	MoH			Eastern-Southern Africa Network	HIV/AIDS expenditure estimates have been produced	98
Senegal								Has expressed interest to WHO	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
South Africa	NHA methodology	EU and National Department of Health	none	1)Department of Health 2)Health Economic Unit Cape Town University 3) Univ. of Durban/Westernville 4)Univ of White-watersrand		Will be institutionalised at regional level	Eastern-Southern Africa Network	SA has used the results from their Health Expenditure Reviews which they produced earlier	1999
Swaziland								Has expressed interest to WHO	
Tanzania	NHA methodology	WB	Price Waterhouse	MoH			Eastern-Southern Africa Network		1999/2000
Uganda	NHA methodology	Sida	Harvard	MoH Planning Unit		Yes more or less	Eastern-Southern Africa Network		1997/98
Zambia	NHA methodology	Sida	Health Economic Unit, Cape Town Univ.	MoH, Planning Unit, CBoH, UNZA			Eastern-Southern Africa Network		1995-98
Zimbabwe	NHA methodology	Sida, USAID	PHR	MoH			Eastern-Southern Africa Network		?
North Africa and Middle East									
Algeria	NHA methodology	WB	WB				Gulf country network	Is beginning for the first time	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Bahrain							Gulf country network	A meeting was held in Bahrain with 8 countries from the region-initiated by WHO Bahrain, United Arab Emirates, Kuwait, Ohman, Saudi Arabia, (Syria, Algeria were observers)* *paid for by WB	
Djibouti	NHA methodology	WHO/ EMRO	WHO/EMRO				MENA		1987
Egypt	NHA methodology	USAID	DDM	MOPH, MoF, National Statistical Agency	MoPH	The Ministry is currently discussing institutionalisation under the planning unit at the MoH	MENA	NHAs estimated in two rounds during 1990s. Currently working on developing locally sustainable NHA capacity	1994/95 98(without TA)
Iran	NHA methodology	WB	WB	National Statistical Institute, MoH	MoH	Institutionali-sing NHA	MENA		1997-1998
Jordan	NHA methodology	USAID	PHR		MoH	Currently working on institutiona-lisation	MENA		1998
Kuwait							Gulf country network	Starting	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Lebanon	NHA methodology	WHO	PHR	MoH		Probably going to institutionalise it	MENA		1997-1998
Morocco	NHA methodology	USAID	PHR	MoH		Interested in institutiona-lising	MENA		
Palestine							Gulf country network	Is starting	
Oman	NHA methodology		?		MoH		Gulf country network	NHA work have started	1999?
Qatar							Gulf country network	Is starting	
Saudi Arabia							Gulf country network	Is starting	
Sudan							Gulf country network		
Syria							Gulf country network	Is starting	
Tunisia	SA		WHO/EMRO	MoH, CSO			MENA	Are building NHA but Satellite Accounts	1998
United Arab Emirates								Is starting	
Yemen	NHA methodology	WB	PHR and WB				MENA		1997
West Bank and Gaza		WB		MoH				Is starting	1997

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
South Asia									
Bangla-desh	- Loosely based on SHA (pre-2000) - Intend to shift to SHA 2000	(Asian Development Bank pre-2001) DFID	IPS (Sri Lanka) previously. No TA required currently.	MOH (C) Data International (P)		Undertaking second round. Intend to maintain on biannual basis.	APNHAN Equitap		1996/1997
Bhutan	TBD	Requires funding. ADB(?)	TBD	TBD			(May join APNHAN in 2001)	MOH interest in starting. Will need funding and TA support.	
India	"Harvard" / SHA in current state estimates	Equitap support for one state account in 2001-3	None	Individual researchers		No current interest by national authorities to produce NHA	APNHAN Equitap	Several State Health Accounts produced on ad-hoc basis. If official interest develops will face funding constraint.	Unofficial national NHA available for 1991. Some state estimates for 1997
Maldives		(SEARO)	(Chulalongkorn University, Thailand)			No current activity	APNHAN		
Nepal	SHA 2000 used to classify public expenditures in 1997	Exploratory funds from SEARO ($3000 in 1999-00). NHEA effort needs funds.	IPS (Sri Lanka) DI (Bangladesh)	Nepal Health Economics Association	TBD	No decision by national authorities to produce official NHA.	APNHAN Equitap	NHEA will receive some funding from Equitap – additional funds required for full effort	1995 1997 (partial)
Pakistan		WB							

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Sri Lanka	Parallel estimates using both natonal framework and SHA 2000	70% national resources: research grants (IPS), 30% by WB	None	MOH (C) IPS (P)	MOH, Central Bank, Census, IPS, MOF, Finance Commission	Established NHA system with routine updates	APNHAN Equitap	Current interest on improving private expenditure estimates/ provincial accounts	1999
East Asia and the Pacific									
Brunei	TBD	National resources ? WHO?				No current activity. Official interest in starting.		WHO discussing advisory visit by IPS (Sri Lanka) in late 2001	
Cambodia		DFID funds may be available initially through HEU, MOH				Nothing started.	APNHAN	Interest by Health Economics Unit, MOH	
China	Adopting SHA 2000	WB May need addl funding for improving NHA.	None	MoH CNHEI		Institutiona-lised	APNHAN Equitap	May need external input (i.e., APHNHAN) to improve private expenditure estimates	1997
Hong Kong SAR, China	Pre-SHA 2000 draft	National resources	IPS (Sri Lanka) previously. No TA required currently.	(IPS, Sri Lanka produced first NHA as turn-key project) HWB (C) DOH (P)	HWB, DOH, HA, Finance Bureau, CSD	Decided to maintain permanently. Next round to start in 2001.	APNHAN	Informal interest indicated in participating in Equitap, but not eligible to utilise EU funds.	1997

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Indonesia	TBD	WB WHO Addl funding required.	Required (funds constraint)			Establishing	APNHAN Equitap	Some overlap between different donor projects. Coordination may be an issue. Interested in accessing regional expertise.	
Kiribati								May be too small to support permanent capacity in country – need to explore potential regional NHA solution.	
Korea	SHA 2000	National resources	None	MOH		Established NHA system with routine updates	APNHAN Equitap OECD	Participant in Equitap, but not eligible for EU funds – needs additional funding for equity work.	1998
Malaysia	TBD	National resources	IPS (Sri Lanka), Harvard	EPU (C) MOH (P)	TBD	Plan permanent system	APNHAN	Commencing 2001	1996
Marshall Islands								May be too small to support permanent capacity in country – need to explore potential regional NHA solution.	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Micronesia								May be too small to support permanent capacity in country – need to explore potential regional NHA solution.	
Mongolia		WHO (partial)	Required	MOH		Still establishing	APNHAN Equitap	WHO TA visit late 2001. Participant in Equitap, but not eligible for EU funds – needs additional funding.	
Myanmar		Funding required. WHO?	Required	MOH			APNHAN	MOH interested in initiating. Needs TA and funding.	
Papa New Guinea	?	ADB	UPecon	MOH NSO		Establishing	APNHAN	Currently on their way	1998-2000 being prepared
Philippines	SNA 1993 Satellite Account	National resources	None	NSCB, UPecon		Established NHA system with routine updates	APNHAN Equitap	Future focus on improving reliability of estimates	1999
Samoa	Implementing SHA 2000	WB	WB (Nandakumar)				APNHAN		
Solomon Island								May be too small to support permanent capacity in country – need to explore potential regional NHA solution.	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Taiwan	SHA 1999 draft. Intend to use SHA 2000 in future.	National resources	Minimal input in 2000 from IPS, Harvard	MOH Chang Gung University		Has produced annual estimates of NHE for many years	APNHAN Equitap	To decide whether to switch estimates to NHA methodology. Participant in Equitap, but not eligible for EU funds – needs additional funding.	SHA-1998 NHE - 1999(?)
Thailand	Implementing SHA 2000	National resources	None	HSRI MOH Chulalongkorn University	MoH	Established NHA system with routine updates	APNHAN Equitap	Focus on improving reliability of estimates/shifting to SHA	1998
Tonga								May be too small to support permanent capacity in country – need to explore potential regional NHA solution.	
Vanuatu								May be too small to support permanent capacity in country – need to explore potential regional NHA solution.	
Vietnam	SHA	ADB. May need addl extended support to institutio-nalise.	UPecon			Establishing		Currently on their way	1998

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Kyrgyz	Egypt (but only for public sector)	WHO	May require	MOH		Establishing	APNHAN Equitap	Working on NHA. Participant in Equitap, but not eligible for EU funds – needs additional funding. Interested in Asian collaboration.	
LAC Latin America and the Caribbean									
Argentina		WB		A NGO produced it			MERCOSUR	Not a NHA study, but a financial study with tables reminding of Harvard method	1995-1998
Barbados							The Caribbean initiative		
Belize		IDB					The Caribbean initiative	Is just about to start	
Bolivia	NHA methodology	USAID (?PAHO?)	PHR used TA from Guatemala	MoH	MoH	More or less institutiona-lised	LAC initiative(now finished)		1995-99
Bolivia	SHA		Requested TA from PAHO		MoH				
Brazil	SHA	WB					MERCOSUR		
Chile		PAHO		MoH			MERCOSUR		

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Colombia	NHA methodology and recently SHA	IDB	consultant	MoH contracted a consultant				Not inside the MoH	1993-1999
Costa Rica		PAHO	PAHO				PAHO's pre-RESSCA 2002	Some studies of health expenditures but no detailed health accounts	
Cuba	SHA	PAHO	PAHO				PAHO's pre-RESSCA 2002	Recently started	
Dominica								Interested	
Dominican Republic	NHA methodology (3 diff est)		Consultant (Magdalena Rate)				LAC initiative(now finished) PAHO's pre-RESSCA 2002		1995
Ecuador	NHA methodology	USAID	PHR together with NGO	NGO	MoH		LAC initiative(now finished)		1998
El Salvador	NHA methodology	PAHO, USAID	PHR				LAC initiative(now finished) PAHO's pre-RESSCA 2002		1996
Grenada							The Caribbean initiative		
Guatemala	NHA methodology		PHR	MoH		?	LAC initiative(now finished)	Has developed AIDS accounts	1995-1997

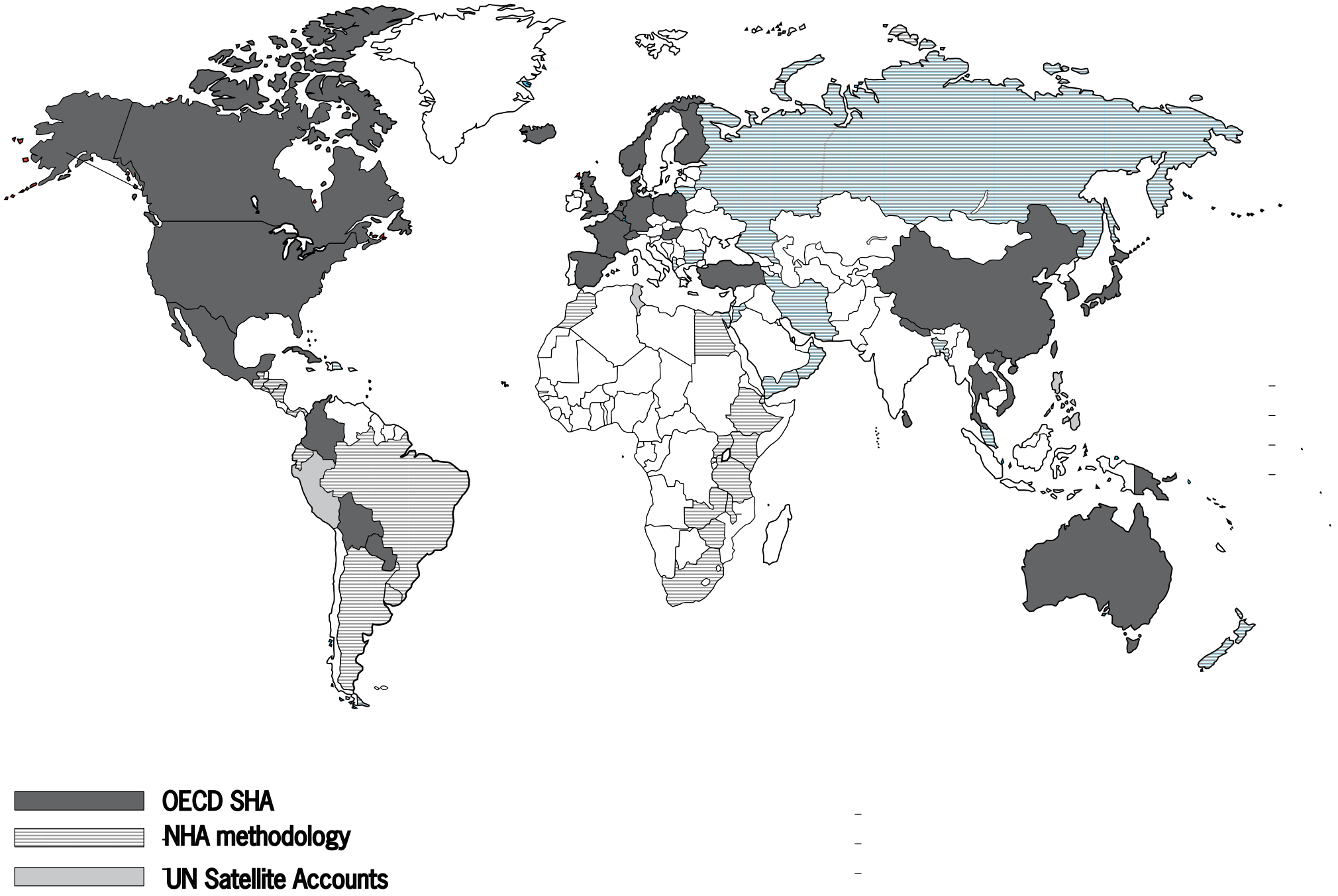
	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Guyana							The Caribbean initiative	No prior health accounts studies but expenditure analysis via DFID	
Haiti								Several prior estimates of health expenditures but no systematic collection of health accounts	
Honduras	NHA methodology	WB	PHR	MoH			PAHO's pre-RESSCA 2002		1997
Jamaica		IDB			MoH		The Caribbean initiative	3 health accounts studies: 1993 by Boston University, a Baseline National Health Accounts (BNHA) by MoH, a revision of the BNHA by Barents Group, LLC.	?
Mexico	NHA methodology	USAID	PHR contracted FUNSALUD (PH)	FUNSALUD		Interested in institutionalisation	LAC initiative(now finished)		1992-1996
Nicaragua	NHA methodology	USAID	PHR contracted FUNSALUD	MoH, MoEduc, MoDefence, Social ins., NGO			LAC initiative(now finished) PAHO's pre-RESSCA 2002	The MoH was not involved from the beginning	1995-1996

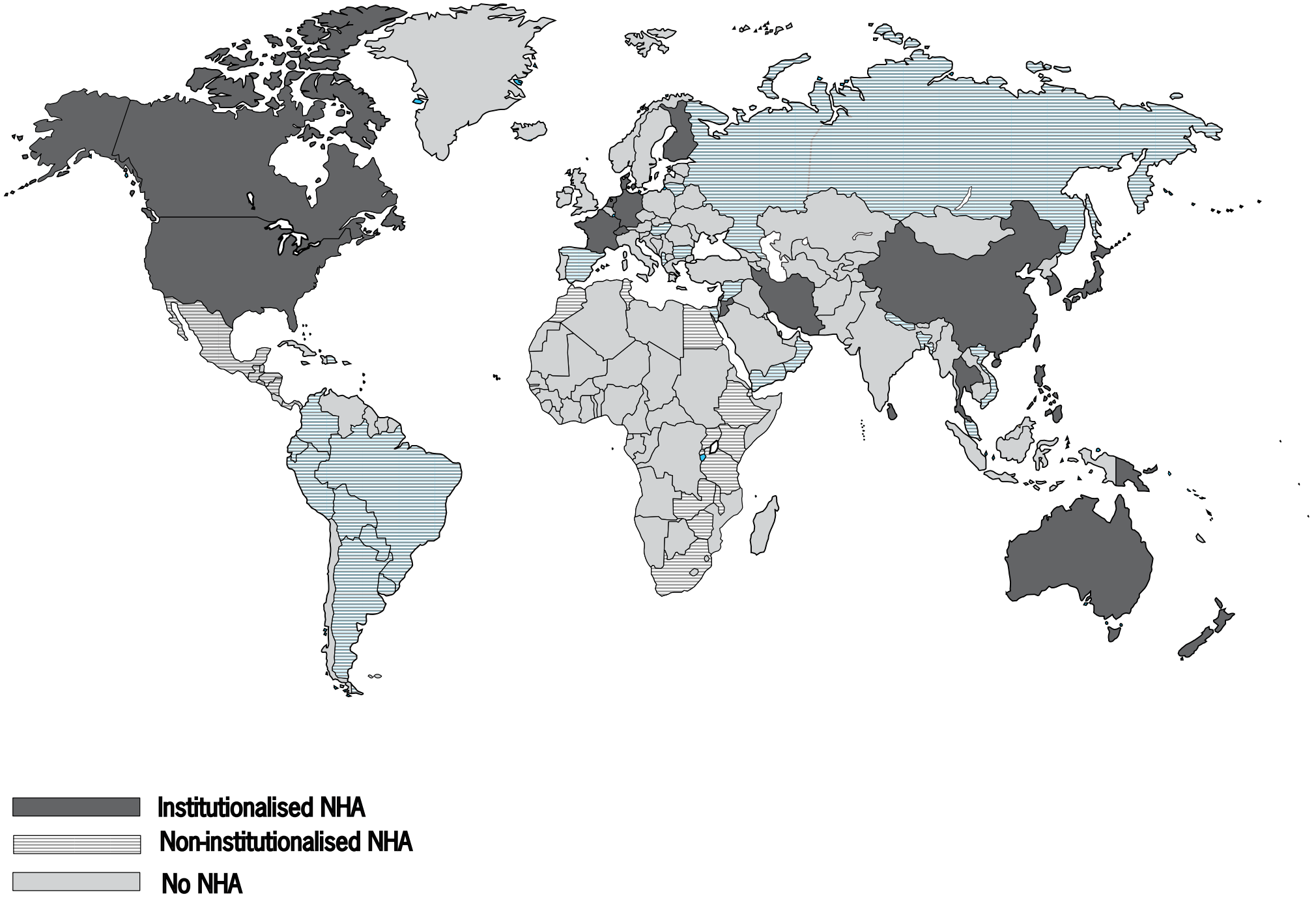
	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Panama	NHA methodology	IADB, PAHO	Consultant (Patricia Hernandez)				PAHO's pre-RESSCA 2002	1.Panama will be the site of the next Red Bobadilla course in NHA, and health accounts will be produced under new IDB loan. 2.The 2002-2003 program of the 'Controloria General' includes satellite health accounts	
Paraguay	SHA (and SNA?)	PAHO			MoH		MERCOSUR	Several studies of health expenditures financed by PAHO and WB. Currently developing health accounts with the SHA method. They may be moving towards the UN SNA definitions due to MERCOSUR agreements	
Peru	NHA methodology	WB	PHR contracted consultant (PH)	MoH, University	MoH	Maybe	LAC initiative(now finished)		1995
Peru	UN SNA	PAHO	PHR contracted consultant (PH)	MoH, University	MoH	Maybe		There is funding in the IDB program but not yet moving	1998

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
St Kitts and Nevis							The Caribbean initiative	now wants to do satellite accounts?	
St Lucia							The Caribbean initiative		
St Vincent and Grenadines							The Caribbean initiative		
Suriname		IDB					The Caribbean initiative		
The Bahamas							The Caribbean initiative		
Trinidad and Tobago							The Caribbean initiative	Prior studies of health expenditures but no detailed health accounts.	
Uruguay	NHA methodology	WB	Consultant (PH)			Yes		May be using another method in the future: UNSNA definitions due to MERCOSUR agreements.	97-99
Venezuela								Several prior studies of health expenditure, but no health accounts. Interested and PAHO has been contacted	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Europe and Central Asia									
Albania	NHA methodology		Barent's Group					First round of NHA	98
Bulgaria								Has produced NHA	
Hungary								Has produced NHA	
Lithuania								Has produced NHA	
Russia	NHA methodology	WB	Dan Waldo (consultant)	MoH, MoF, MoEconomy, Goscanstat, Federal Social Insurance Organisation		No		The MoH people do not want it institutionalised since they make more money working as consultants on NHA than working for the government with NHA	1996-99
Slovakia								Has expressed interests in the mid 1990s but due to corruption and the government today nothing has happened. However, some Slovakians have participated in HSPH's workshop and at OECD meetings	

	Method	Financial Support	TA	Who produces it?	Steering committee	Current status on institutionalisation	Network	Comments	Latest year produced
Turkey								A bid is out in the spring of 2001 for TA producing NHA	


OECD SHA
NHA methodology
UN Satellite Accounts


Institutionalised NHA
Non-institutionalised NHA
No NHA

List of Health Division Documents:

1997:1 Policy for Development Cooperation
Health Sector

1997:2 Política para la Cooperación para el Desarrollo
Sector Salud

1997:3 Position Paper
Population, Development and Cooperation

1997:4 Positionspapper
Befolkning, utveckling och samarbete

1997:5 Marco de Referencia para la Cooperación para el Desarrollo
Población, Desarrollo y Cooperación

1997:6 Strategy for Development Cooperation
Sexual and Reproductive Health and Rights

1997:7 Estrategia para la Cooperación para el Desarrollo
Salud y Derechos Sexuales y Reproductivos

1997:8 Handbook for mainstreaming
A Gender Perspective in the Health Sector

1998:1 Issue Paper:
Maternal Health Care, by Staffan Bergström

1998:2 Issue Paper:
Supporting Midwifery, by Jerker Liljestrand

1998:3 Issue Paper:
Contraception, by Kajsa Sundström

1998:4 Issue Paper:
Abortion, by Kajsa Sundström

1998:5 Issue Paper:
Female Genital Mutilation,
by Beth Maina-Ahlberg

1998:6 Issue Paper:
Adolescent Sexuality Education, Counselling and Services, by Minou Fuglesang

1998:7 Issue Paper:
Discrimination and Sexual Abuse Against Girls and Women, by Mary Ellsberg

1998:8 Issue Paper:
Health Care of the Newborn,
by Ragnar Thunell

1998:9 Issue Paper:
Men, Sexuality and Reproductive Health,
by Beth Maina-Ahlberg, Minou Fuglesang and Annika Johansson

1998:10 Issue Paper:
Illicit Drugs and Development Cooperation,
by Niklas Herrmann
– Replaced by 2000:2 –

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