Framework for assessing maturity of health accounts institutionalization

World Health Organization

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ISBN 978-92-4-007945-8 (electronic version)
ISBN 978-92-4-007946-5 (print version)

Suggested citation. Framework for assessing maturity of health accounts institutionalization. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Contents

Acknowledgements

This document is the product of the collective effort of many people around the world, led by the Health Expenditure Tracking team in the Health Financing and Economics Department at the World Health Organization (WHO). The core writing team included Ke Xu, Maria Aranguren Garcia, Lachlan McDonald, Angelique Rwiyereka, Natalja Eigo and Hapsa Toure.

We thank those who provided valuable comments on the document: Joseph Kutzin, Peter Cowley, Hélène Barroy, Fahdi Dkhimi, Dongxue (Wendy) Li, Julien Dupuy, Chandika Indikadahena, Justine Hsu, Matthew Jowett, Inke Mathauer, Bruno Meessen, Laura Rivas, Andrew Siroka, Susan Sparkes, Ningze Xu and Eva Zver from the Health Financing and Economics Department, WHO; Karishmah Bhuwanee from Abt. Associates; Deepak Mattur from UNAIDS; Cicely Simone Thomas from the World Bank; Shaheda Viriyathorn from International Health Policy Program; and global health accounts experts Patricia Hernandez and Cor van Mosseveld.

We are grateful to numerous individuals and agencies for their support in making this document possible: Kingsley Addai Frimpong, Ogochukwu Chukwujekwu, Diane Muhongerwa, and Juliet Nabyonga from the African Region; Awad Mataria from the Eastern Mediterranean Region; Baktygul Akkazieva and Tamás Evetovits from the European Region; Claudia Pescetto from Region of the Americas; Valeria De Oliveira Cruz and Tsolmongerel Tsilaajav and from South-East Asian Region; Ding Wang and Lluis Vinals Torres from Western Pacific Region, and Diana Gurzadyan and Gael Kernen from the Health Financing and Economics Department; David Clarke from the Special Programme on Primary Health Care, WHO; Jan Borg from Abt. Associates; Sabine Musange from the University of Rwanda; Donald Shepard from Brandeis University, Nirmala Ravishankar from Thinkwell; and Health Accounts experts Magdalena Rathe, Ezrah Rwakinanga and Angelica Santos.

The document benefited from valuable comments from many countries' health accounts experts and policy-makers during the regional meetings in WHO regional offices for Africa, South-East Asia, Western Pacific and Europe. It benefited from work done in countries that piloting the early version of the framework.

Finally, we thank the Bill & Melinda Gates Foundation for their funding support to the wider health accounts programme at WHO, of which this framework is an important part.

Abbreviations

FMIS	Financial Management Information System
GHED	Global Health Expenditure Database
HA	Health accounts or Health Accounting
HAPT	Health Accounts Production Tool
HMIS	Health Management Information System
SHA	System of Health Accounts
WHO	World Health Organization

Executive summary

This document describes a qualitative framework and a detailed set of guidelines for assessing the maturity of countries' health accounts (HA) institutionalization. HA organize and report information on countries' health spending using a consistent and coherent framework. They reveal how health systems are structured, and provide a snapshot of what services are provided, to whom, and how they are financed. When reported repeatedly over time, these snapshots show time trends, yielding important insights into health systems' dynamics.

Institutionalization of HA involves the routine government-led and country-owned production and application of HA data. The more institutionalized HA is within countries, the better ministries of health can evaluate health system performance and adjust policy and programmes accordingly. This enhanced stewardship function is a key reason why the institutionalization of HA is a health policy goal in many countries.

A focus on institutionalization can reveal much about the extent to which HA information is integrated into countries' broader management and use of data. Producing HA depends on collecting health expenditure information from various sources. Therefore, an assessment of HA institutionalization should reveal much about countries' information system architecture, data exchange platforms and digital data technology. Additionally, by assessing how HA data are demanded and used, this analysis can identify whether HA data influences key deliberative processes of government, such as policy dialogue and budget processes.

The framework presented in this document is for officials within ministries of health, country HA teams, and partners (domestic and international) that are relevant to HA production. It is structured into four interconnected domains: a. demand for HA data, b. governance and financing arrangements, c. institutional technical capacity, and d. dissemination and use of information. Within each domain are several key elements, including a set of standard questions that can be applied to all countries regardless of the maturity of HA institutionalization.

The framework aims not to create a score, or rank countries, but to create a narrative that helps deepen the understanding of where countries sit in the institutionalization process and the factors that facilitate or hinder progress. The results of the assessment should also act as a guide for further investments in resources and effort. Countries are encouraged to share their results with the World Health Organization to build a broader knowledge base and share best practices.

The model for institutionalizing HA is specific to each country. It reflects different historical factors, data usage cultures, capacities, priorities and organizational arrangements. Accordingly, the framework is not meant to be definitive or prescriptive. Governments and partners are encouraged to tailor the questions presented in the framework when assessing HA institutionalization. Experimentation with different summary metrics can also occur if desired.

PART A

Introduction

Background on health accounts

Good-quality accounting and reporting of health expenditures is a foundation of effective stewardship of health systems. Complete, reliable, and well-organized information on health spending in a given period shows how health systems are structured and gives a snapshot of what services are provided, to whom and how they are financed. When reported repeatedly over time, these snapshots yield important insights into health systems' dynamics. This wealth of information is critical to the accountable and transparent governance of health systems. It can also be a crucial input into policy and planning, programme design and implementation, and evaluating the efficiency, effectiveness, and equity of health resource allocations *(1)*.

Although health accounts (HA) have a long and established history (see Annex 1), only since the turn of this century has there been a common framework across countries for collecting, compiling and analysing data on health expenditures to and within health systems.[1] The System of Health Accounts methodology, released in 2011 (SHA 2011), is the latest manifestation of this globally recognized framework. It underpins countries' national health accounts and is the basis for health expenditure data published in the WHO's Global Health Expenditure Database (GHED).

SHA 2011 applies an integrated and comprehensive methodology to tracking health expenditure within a country by using standard classifications. Focusing on the final consumption of health care, it tracks resource flows through the health system, from their sources (funding sources, agents, and financial arrangements) and patterns of provision (locations and inputs factors) through to their uses (health care functions, diseases and programmes).

The SHA 2011 framework has proved to be a valuable tool for governments, external stakeholders and the public to understand health expenditures at country and global levels *(2)*. It also yields important policy-relevant information. For example, data on what services are purchased and by whom can show whether a country is making progress towards universal health coverage. By depicting resource flows to the various core functions of the health system, the SHA 2011 framework can also help identify whether the health system is equipped to meet future challenges. This includes challenges posed by epidemiological and income transitions – which change demands for service delivery – and by outside threats, such as pandemics – which require investments in health security. While HA can shape political decision-making, it is an apolitical framework.

[1] Note, the terms "health accounts" and "health accounting" are both represented by the acronym "HA" in this document.

Consistent measurement of health expenditures within countries is a global public good. In addition to being useful for country benchmarking, consistent measurement can help evaluate countries' relative progress in meeting regional and global commitments, such as Sustainable Development Goal 3.[2] It can also facilitate assessments of details of global health spending – for example, by place of residence, income level, funding source and disease category.

The aim of this document

The institutionalization of HA is key to safeguarding the sustainability, quality and effective use of HA information. According to the concept initially espoused *(1)*:

> ***HA institutionalization is . . . [the] routine government-led and country-owned production and application of an essential set of policy-relevant health expenditure data using an internationally accepted health accounting framework.***

The more institutionalized the production of HA is in a country, the more integrated health expenditure information is within the broader ecosystem of financial and health management information reporting. This is an essential part of health system stewardship and responsive governance and potentially a valuable input into the broader deliberative processes of government (Box 1).

Countries are at different stages of maturity in their HA institutionalization, and some are yet to begin their institutionalization journey. This document provides a framework and practical reference guide to help countries work out where they sit on the institutionalization pathway, their general trajectory (i.e. whether they are advancing, sustaining or regressing over time), and the reasons why. It is aimed at officials within ministries of health, country HA teams, and partners (domestic and international) that are relevant to HA production. The results should help these audiences identify key factors that affect progress, and see where improvement can most readily occur.

The framework is based on widespread and detailed consultations with experts and health accounts stakeholders worldwide (see Annexes 2 and 3 for details) and reviews of relevant documents on HA development, including those published by the WHO regions *(3,4)*.

Box 1: Why the focus on institutionalizing HA?

A focus on the extent to which HA processes are institutionalized provides important insights into how HA is meeting the health sector's monitoring and evaluation needs. The more institutionalized and country-owned the production and dissemination of HA information, the better ministries of health, development partners, and other stakeholders can be informed on the health system's performance. This can lead to a more participatory and inclusive dialogue about health policy and priorities.

Institutionalization assessments can also provide insights into the links between HA and countries' broader information management systems. Health and public financial management information systems are essential enabling factors for producing HA. Accordingly, assessing the HA system should also reveal much about countries' information system architecture, data exchange platforms and digital data technology.

A focus on institutionalization can reveal the extent to which HA information is integrated into the broader health information and public financial management systems. Reliable and timely HA information is valuable in helping governments shape policy, prioritize activities, allocate resources against those priorities and evaluate spending performance. By assessing how HA data are demanded and used, the institutionalization assessment can identify whether HA data influences key deliberative processes of government, such as policy dialogue and designing the health budget.

[2] Sustainable Development Goal (SDG) 3 is "[t]o ensure healthy lives and promote well-being for all at all ages." The targets of SDG 3 focus on various aspects of healthy life and healthy lifestyle. Progress towards the targets is measured using 21 indicators.

This document introduces the assessment framework and guides users in its application. It is structured into three parts. Part A provides a brief overview of HA and the importance of their institutionalization. Part B focuses on assessing countries' HA institutionalization and introduces the framework of analysis before detailing its application in assessments by stepping through each relevant domain and the attendant set of guiding questions. Part C summarizes and looks forward.

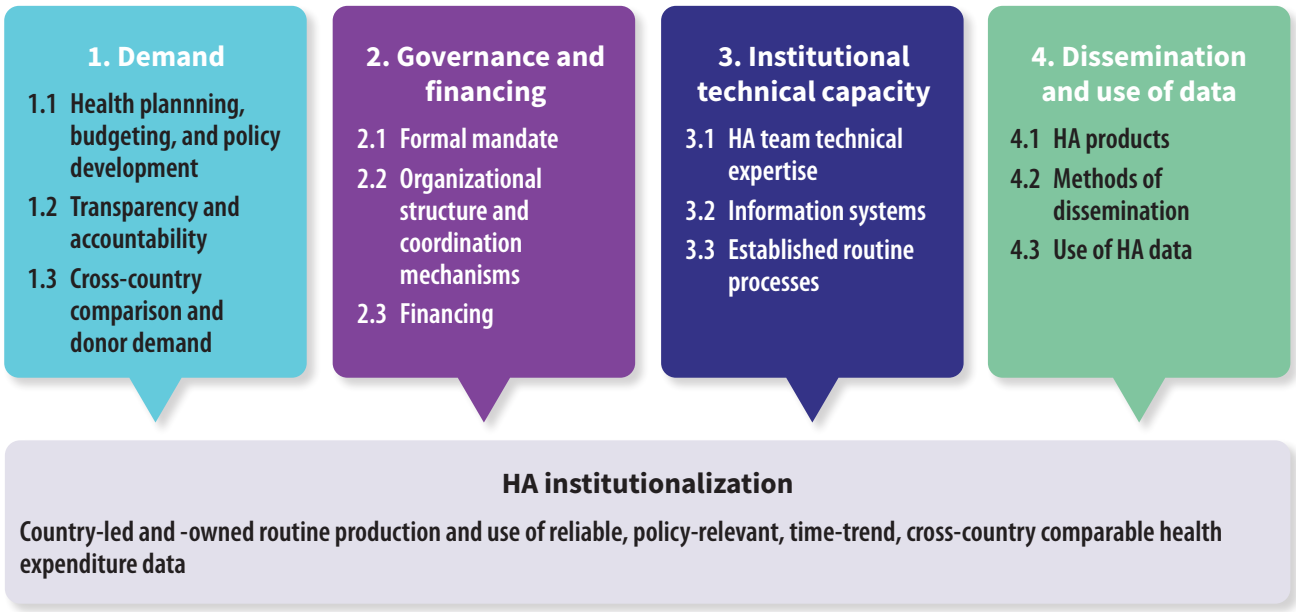
PART B

Assessing the maturity of HA institutionalization

A framework for analysis

Although each country is unique, the institutionalization of HA is shaped by a common set of domains and factors (Figure 1). These include a. demand for HA data, b. governance and financing arrangements, c. institutional technical capacity, and d. dissemination and use of information. Within each domain are several key elements. Some of these elements are at the core of the HA process[3] (e.g. institutional capacity and distribution), while others are enabling factors.

Fig 1. Framework for assessing the maturity of HA institutionalization



[3] The HA process includes all the processes to complete an HA exercise (data production, analysis, validation, dissemination, etc.).

The framework is not prescriptive; it does not promote any specific methods or pathways for institutionalization. Instead, it focuses on common elements that are likely to apply in all countries regardless of the institutionalization model. Each element is accompanied by a set of questions that should be applicable in most country contexts. This allows users to gather relevant evidence on the state of each aspect of HA institutionalization and, thus, on the overall maturity of the process within each country. The set of guiding questions also assists with cross-country learning.

The conceptual underpinning of the framework is that the institutionalization of HA is a process, but it is not necessarily a linear process. Nor is institutionalization binary: one cannot say if a country has "institutionalized" or not. Instead, institutionalization is a dynamic, complex, and ongoing process with many influences, involving often parallel activities, multiple stakeholders, continuous change, setbacks and feedback loops.

Reflecting this, the four domains presented in the framework are interconnected. For example, although a country may have a formal mandate to produce HA, it requires the publication of good-quality, tailored and accessible HA products for people to effectively read and interpret the results. The more that governments and other stakeholders appreciate the usefulness of HA data, the greater the likelihood that the HA production process will be sufficiently resourced. Adequate resources, in turn, are essential for building institutional capacity and the ability to continue producing high-quality and reliable outputs that meet the needs of planning, budgeting and policy.

Changes in any single domain can influence the whole process, resulting in a new equilibrium that consists of either progress or regress of the institutionalization process. For example, new political leadership or new leadership of a hosting agency can advance HA institutionalization. Conversely, turnover of HA staff without timely replacement can weaken capacity, slow momentum and jeopardize sustainability. Balance among the four domains is needed if institutionalization is to progress and the impact of any disruptions is to be minimized.

These factors help to explain why the framework takes a holistic view of the maturity of countries' progress. Results are deliberately left qualitative to reflect the fluid ways the elements interact and play out. It is envisaged that the resulting country narrative can function as a measure of overall progress and as a lodestar for government and partners for charting the way forward.

Applying the framework

The rest of Part B details each of the four domains using a common approach: providing an overview of the domain before drilling down into the individual elements and the associated guiding questions for assessment of institutionalization.

1. Demand

Foundational to institutionalizing any administrative process is whether there is effective demand for it. There is always demand for health expenditure data in some form. Who demands HA information can be an important determinant of institutionalization. When the demand for HA information is predominantly external, and not country-led, for instance, a government may take more of a hands-off approach to HA than if that demand was coming from within government agencies. The converse is also likely to apply: the more valuable HA outputs are to agencies within the government and/or health insurance agencies, the greater the potential demand for good-quality HA production processes *(4)*.

Additionally, the type of demand is important. Demand for HA data may stem from a genuine desire to use the results to drive policy. Demand may also be generated for superficial purposes, being seen as a compliance exercise, a condition of external funding or simply a reporting requirement imposed by development partners. Integrating demand for HA information into decision-making is likely to be a strong driver for institutionalizing HA compared to approaching it as a box-ticking exercise.

The framework helps users assess where the demand for HA information comes from and why. It helps gauge the different dimensions of domestic demand, within government and across civil society, alongside any demand from external partners. In identifying the purpose of the demand and its possible impact, the framework encourages a deeper analysis of different users' general comprehension of the data, their preparedness to use data, and the extent to which demand is ongoing and sustainable. Importantly, while applying the framework key gaps in demand may also be revealed. For instance, a relevant ministry or agency may not be demanding HA data, or there may be strong demands for HA data, yet the available data is not suitable. Uncovering these gaps, and the reasons why they exist, is an important part of the assessment.

Guiding questions: 1. HA demand

- **Who demands what health spending data and for what purpose?**

User	**What HA data?** *Series, classifications, indicators, period*	**For what purpose?** *Health planning, budgeting, monitoring, and evaluation, policy development*	**What impact has the HA had?** *(Please point to any decisions made/ changes that were based on the HA data)*
Ministry of health (MOH)			
Government beyond MOH			
Disease/health programmes (specify)			
Development partners/donors (specify)			
Health insurance agencies (public and private)			
Academic institutions (specify)			
Civil society (specify)			
Others (specify)			

2. Governance and financing

Governance is a broad catch-all term that encompasses the systems and processes of setting the direction and mechanisms for oversight and evaluation. It includes elements such as the division of authority between different parties, rules and norms of behaviour, resourcing and tools for ensuring accountability.

The critical aspects of governance – those that shape institutionalization – include clarity and formality in the assignment of responsibility for producing HA (mandates); the presence of an enabling environment for collaboration and performance; and adequate resourcing.

2.1. Formal mandate

A mandate is an official order to undertake a particular action given to an institution or person, and may include rights to collect data from different authorities and data sources. Mandates can come from various instruments with varying degrees of formality, including laws passed by the legislature, pronouncements (such as royal decrees and other official instructions), and office orders issued by a lawful authority, such as a minister or president.

A strong formal mandate that obligates the production and use of regular HA is a cornerstone of the institutionalization process. Most notably, it can help insulate HA from fluctuations in political will. Some European parliaments demonstrate best practices in legislating and enforcing the production of HA data *(5)*, whereas in countries lacking formal mandates, events like changes in leadership and exposure of HA mechanisms to financial mismanagement can weaken government commitment to the production and use of HA.

To oblige the production HA, mandates must be effective. There are many cases in which governments and administrative bodies have the formal responsibility and right to act in a certain way, yet little happens because mandates remain underfunded and/or neglected.

An effective mandate for the production of HA, therefore, implies that the necessary legal and institutional frameworks are in place, that there is clear demarcation of responsibility and authority for implementation, and that sufficient resources (financial, human and otherwise) are allocated to allow the responsible body to deliver on this mandate.

Guiding questions: 2.1 HA mandate

- **Is there a formal mandate for producing HA data? If not, what (if anything) requires the production of HA?**

- **If there is a formal mandate:**
  - What form does the mandate take (e.g. regulation, government administrative order, decree, international or regional mandate; provide citation, reference and link, if possible)?
  - Who provides the mandate (e.g. parliament or monarch)?
  - When was the mandate given?
  - Is the mandate accompanied by sufficient authority and resources to be effectively implemented?
  - Has the mandate been implemented?

2.2. Organizational structure and coordination mechanisms

The institutionalization of HA requires countries to take ownership of the HA production process. This, in turn, requires countries to build the necessary organizational structure – establish who is responsible, who is the host and who are the producers of the HA, and the mechanisms to coordinate among them. In more mature and well-functioning bureaucracies, such organizational structures with clear functions and mandates for producing HA may exist and work. In less-developed contexts, such organizational structures may not exist or, if they do, may not deliver results.

Development partners can play a critical role helping establish and build the requisite organizational structures and processes in low- and middle-income countries through investments in consultants, surveys and outputs. However, for these organizational structures and processes to be fully institutionalized, they should be embedded in functioning national agencies. Accordingly, external investments should be accompanied by plans to ultimately transition responsibilities to being under country ownership.

The ultimate responsibility for HA should reside with the government. However, several agencies can feasibly be the host organization – most likely the ministry of health or the national statistics office, or one or more public health institutes or academic institutions. One potential advantage of separating ownership and hosting functions of HA is to encourage politicly independent and unbiased production and distribution of the HA results (or at least minimize perceptions of bias). Production functions may also be split across participating organizations; this promotes participation, but may inhibit coordination.[4]

Guiding questions: 2.2 HA organizational structure and coordination mechanisms

- **Which government unit is the owner of HA data (with the authority of final approval for publication)?**
- **Which institution is the producer?**
  - What is the name of the agency?
  - What is the nature of the agency (government agency, academic, independent agency)?
  - What other tasks does the agency perform besides producing HA data?
- **Which partners (domestic and external) are involved in the HA production, and what are their roles?**
- **Which agencies/institutions/sectors are responsible for providing the different types of HA data?**
- **Are these agencies/institutions/sectors routinely engaged in the HA data collection process?**
- **Which agency/organization is tasked with leading the coordination of involved entities?**
- **What are the mechanisms (if any) for coordinating among partners/stakeholders (e.g. technical or stakeholders committee)?**
- **Are there reward or sanction mechanisms, or incentives for institutions/ministries/insurance to provide data?**

Effective coordination among the various stakeholders in HA production is key regardless of ownership and hosting arrangements. HA production requires a multi-stakeholder process; there are many providers of information (e.g. governments, development partners, social health insurance agencies and the private sector) who are also potential

[4] In Brazil, for example, several separate institutions are involved in HA production in a joint effort, including the Ministry of Health, the National School of Public Health and various statistical offices, research institutes. In Tunisia, the HA team is organized as a supra-agency comprised of individual officers located in individual participating agencies.

users of HA information. Other interested parties exist within the government (e.g. prime minister's office, ministry of finance, and the parliament) and civil society. Some entity – a committee or a health sector body – should be responsible for leading this coordination. An emphasis on fostering a positive culture of collaboration, with clearly defined roles and responsibilities of the various agencies involved in HA production, plus clear lines of accountability to the responsible authorities, is also crucial. Lead agencies can also play a key role by coordinating, encouraging communication between, and bringing together stakeholders.

In many countries, gaining engagement beyond the official channels (i.e. government and development partners) in the HA process is an enduring challenge. The private sector (e.g. service providers and insurance companies) may be unaware of the HA process and/or not see the benefit of participating; some might also see the HA process as a covert way for the government to access information for taxation purposes. Finding ways to improve and normalize private sector engagement in the HA process is therefore important.

2.3. Financing

A clear mandate and a well-developed organizational structure do not automatically guarantee the production and dissemination of HA data. Responsible agencies must also be given enough resources (e.g. staff, operating budget, capital equipment) to fulfil their assigned functions. Many resource-constrained low- and middle-income countries receive support from development partners to cover expenses. However, as part of the local ownership embodied in institutionalizing HA, countries must progressively and sustainably absorb these production costs themselves. This, in turn, requires medium-term resource planning embedded within annual government budgets.

The financing strategy for HA should ensure that resources are available for all necessary inputs into the process, including staff, equipment and all essential functions (such as data collection, data processing, quality assurance, publication and dissemination). Ongoing investments should also be made into improving local staff capacity (via training and other activities), upgrading equipment and improving processes (e.g. quality assurance and control procedures).

Guiding questions: 2.3 HA financing

- **How are health accounts funded?**

Input and activities	Government *(regular budget or ad hoc funding)*	Donors *(specify)*	Other *(specify)*
Staff			
Office space, equipment			
Technical support			
Training			
Data collection/surveys			
Data cleaning, entry and triangulation			
Data mapping and analysis tools/software investment			
Database, report, briefs and other HA products			
Dissemination of findings (e.g. printing, speeches, newspaper articles, flashcards, flyers)			
Other (specify)			

3. Institutional technical capacity

Institutional technical capacity determines many of the features that influence the quality and usefulness of HA data, including (but not limited to) quality assurance processes, the level of disaggregation of HA data and reporting. The technical ability of staff working within responsible agencies, the effectiveness of information management systems, and the broader enabling environment can all facilitate or inhibit cohesion. Assessing these aspects of technical capacity can help determine whether (and where) gaps exist, whether the current capacity level is sustainable, and where further investments in building capacity may be required *(6)*.

3.1. HA team technical expertise

The production of HA and the dissemination of results to various audiences with different needs and levels of technical sophistication is a complex process that requires high technical capacity.

The technical capacity of HA teams depends, in large part, on the availability of a broad range of essential skills. HA is an inherently multidisciplinary activity; it therefore requires a variety of knowledge and skills, including health economics, public health, statistics, public finance, data management and data analysis. Of course, staff working on HA should also have good knowledge about the health system in which they are working and about SHA 2011. People with these necessary skills may be sourced from within a country or, if unavailable locally, internationally (often via consultants).

Also important in determining technical capacity is the nature and duration of staff's tenure working on HA. A high staff turnover may weaken the technical capacity to undertake HA because important institutional memories are often lost when staff move on. Thus, employees on permanent and part-time contracts are likely to provide greater scope for business continuity than short-term consultants. However, technical capacity may also erode when long periods elapse between two HA exercises. High-quality HA training and thorough documentation of HA processes can help mitigate these risks by retaining current staff and preparing new recruits.

Besides training workshops, the regular production of HA is important for building technical capacity within staff and for addressing gaps and weaknesses in capability. To sustain effective HA teams, HA should be viewed as a vocation with professional development opportunities beyond learning on the job. The international and regional network provides staff opportunities to share experiences, knowledge and cross-disciplinary learning.

Technical capacity can be strengthened by increasing synergies between individuals and teams to unlock greater organizational potential. In this sense, the governance domain, as described above, and the technical capacity domain fit hand in glove.

Guiding questions: 3.1 HA team technical expertise

- **How many exercises of HA has the country produced and when?**
  HA production exercise refers to a period when a country collects, produces and analyses HA data. For example, a country could produce 3 years of HA data in the same exercise.
- **In the past 5 years, how many permanent staff working on HA have been turned over (number and percentage of total)?**
- **What support/resources are available for new recruits to facilitate their rapid onboarding into the post and their work?**
- **What professional development opportunities, beyond routine training are available to staff working on HA (e.g. attendance at conferences, secondment, rotation)?**

Please fill in the following table (if you have only one HA production exercise, fill in the latest exercise column).

	First exercise	Latest exercise
General information		
Year of the production		
Years of data produced (fiscal years covered)		
Classifications produced		
Number of full-time staff on the team		
HA training provided; if yes, indicate by whom and topics		
General knowledge *Indicate if there are personnel with expertise in the following areas (options: staff or domestic or international consultant)*		
General statistics		
General accounting		
Health systems policy		
Macro – fiscal/public finance		
SHA2011 knowledge *Indicate if there are personnel with expertise in the following areas/SHA11 classifications (options: staff or domestic or international consultant)*		
HF/FS		
HC/HP		
DIS		
HK		
Pharmaceutical		
Primary Health Care (PHC)		
Other (specify)		
Outline WHO's role in technical support		

3.2. Information systems

Well-functioning information systems capture and process information, store it digitally, and make it available to users in a timely manner and in ways that support further action. In the context of health systems governance, this may include monitoring, evaluating, planning, budgeting and policy-making. The power of information systems is increased when data are linked, enabling users to gain access to information from multiple sources.

HA is not an information system, but producing HA depends on accessing expenditure information from various information systems. Information on executed public expenditure is often sourced from the government's financial management information system (FMIS). Information on private health spending, particularly households' out-of-pocket expenditure, is sourced from surveys such as health facility surveys, household surveys and other sources of information, such as national accounts data and health insurance claims data *(6)*. Data on external funding can be accessed through various vehicles, such as on-budget reporting and survey tools for off-budget expenditure.

A health management information system (HMIS) can be an important input into HA production. HMISs vary from country to country, though, in general, they collect and store health-related data from various sources, including health service activities within facilities, to support performance assessment and strategic planning. Health data can be a useful complement to the information on expenditure when preparing HA. When health spending data are not sufficiently disaggregated between inpatient and outpatient care, for example, information on health service activities within facilities can be used to generate relevant splits. The more detailed the categorization of HMIS data – for example, by geography, facility type and patient characteristics – the greater the potential value for HA production.

The quality of HA outputs – and their usefulness for decision-making – is directly linked to the quality, completeness and timeliness of inputs. To the extent possible, the institutionalization of HA process should be based on interoperable and digitalized information systems that provide timely and accurate information. However, key information from both public and private sources may not be available or accessible to HA teams. Data presented in FMIS, HMIS and elsewhere may be incomplete or not presented in a way that fits the purpose of HA.[5] Moreover, essential surveys of household expenditure can be quite outdated. This means that countries may need to estimate household expenditures using old spending information scaled up for macroeconomic growth, and make strong assumptions that the structure of households' health spending remains broadly unchanged.[6] There may be also issues with the representativeness of health expenditure data in household surveys.

The functioning of information systems is a far broader issue than HA. Nonetheless, access to a network of digital information systems is a key step towards building the technical capacity for HA. When designing information system architecture – including data exchange platforms and reporting – consideration should be given to users' needs, including the producers of HA. Interoperability can also strengthen the capacity to undertake quality assurance by enabling validation and triangulation.

Effective integration of HA into existing information systems is also likely to be cost-effective. Without access to underlying information systems and standardized routine reporting processes, HA production will mainly rely on primary data collection and specialized surveys, which can be time-consuming, costly and difficult to conduct. Survey instruments will nonetheless remain essential for capturing information that is not included in routine reporting systems, such as data from the private sector and civil society.

Shifting away from labour-intensive, paper-based information collection to automated and digitized systems speeds up data transmission, reduces costs and limits errors. The capability to make informed decisions is improved considerably when information on health expenditures is up to date. Advances in computing power, combined with declining

[5] For example FMIS can look at public spending from the vantage point of the central government. This means that spending at the crucial subnational level can be overly aggregated, obscuring key details necessary for the HA. This further highlights the importance of disaggregating HMIS data for interpreting FMIS data.

[6] In some countries 10 years or more can elapse between rounds of Household Income and Expenditure Surveys. Structural changes in expenditure patterns that occurred during COVID-19 are also likely to present challenges for estimating households' health expenditure using data surveys.

Guiding questions: 3.2 HA information systems

- **What are the major sources of information for various types of health expenditure?**

	Major source(s)	Digitalized information?	Can the HA team routinely access information?	Can detailed items on health spending be identified for HA?
Health expenditure by central government				
Spending by subnational government				
Spending by households				
Spending by external development partners				
Any other major sources of spending (specify)**?**				

- **Is there a government financial information system in place?**
  - Are the data publicly accessible? If not, does the HA team have routine access to the data?
  - Is the information in FMIS linked to spending information in other databases (e.g. HMIS)?
- **Has there been any reliance on special sampled survey instruments and primary data collection the most recent HA?**
  - If so, what was the survey? (Please list if there is more than one.)
  - When was the survey(s)?
  - Who administered and funded the survey(s)?
  - How was sampling for the survey(s) determined (e.g. nationally representative sample)?
- **If there was a household survey, was it based on Classification of Individual Consumption by Purpose or on some other classification systems?**
- **Is there any further manipulation/estimation of spending data based on the information presented from major sources?**
- **Is the information in the HMIS used to produce health accounts? (If so, how?)**

On HMIS, please fill in the following.

How often are the data updated?	
Are the data in electronic form?	
Do the data include service utilization by outpatient, inpatient, prevention, etc.? Please specify	
Do the data include service utilization by the types of health care providers? Please specify	
Do the data include service utilization by disease? Please specify	
Do the data include international classification of diseases? Please specify	
Do the data include service utilization by age? Please specify	
Do the data include financial information? Please specify	

technology costs, facilitate greater analytical capacity, even in the most resource-constrained places. This can help shorten the time between collection of data and publication.

The experiences of countries that have successfully applied novel approaches to integrating institutions' and facilities' financial and other data can inspire others. Of course, as data become more digitized and widely available, the importance of policies and practices to protect sensitive information (such as patient data) grows.

3.3. Established routine processes

To sustain institutional capacity, it is important that countries standardize and follow a set of operating procedures when producing HA. Objective and procedure-driven approaches provide HA teams with essential consistency and predictability in their activities. This helps to reduce errors and results in a higher quality product overall.

Routine processes can exist all along the HA production cycle (e.g. data collection, estimation, validation, mapping, and dissemination and usage). Most salient is that countries consistently comply with SHA 2011, which provides useful classifications of health spending, captures resource flows, and safeguards the comparability of HA information over time and place. Countries may have customized rules and procedures for accounting for health expenditures, though these should ultimately be built on the foundations of SHA 2011.

To assist with this, WHO's health accounts production tool (HAPT) provides a global platform for HA production at the country level, and is based on the SHA 2011 framework. HAPT was developed to streamline and simplify the HA production process and reduce the need for technical assistance; thus facilitating the institutionalization of HA *(7)*.

Standard operating procedures help mitigate the risk of political interference in the HA production process. This improves resilience to changes in government priorities, and helps with data quality assessments, which must be objective, independent and rigorous. The method chosen for data quality assessments should follow standardized criteria that all stakeholders agree on at the outset.

Countries may benefit from producing internal guidelines that document the tasks required and skills needed when implementing the various phases of HA. Doing so would help capture the benefits of routine processes and help mitigate the risk of institutional knowledge being lost with staff turnover.

Guiding questions: 3.3 HA established routine process

- **Is SHA 2011 the methodology for HA production?**
- **What are the country-specific methods for producing HA?**
- **Is there a proper and standard documentation process to facilitate knowledge transfer on core HA functions and activities? (Is there a list of routines, data sources, focal points/areas in participating organizations, calculation and estimation methods and mapping, revisions and their purposes for HA production, and so on?)**
- **What is the data validation process (mapping, trends, metadata and revision)? Is there any guideline for the data validation process? Please describe it or provide a document.**
- **Does the country use HAPT for data mapping and analysis? (If not, what software/tool is used?)**
- **Does the country use statistical software (e.g. STATA, R, Python) for data cleaning, mapping and analysis? (If not, what software is used?)**

4. Dissemination and use of data

The end-products of the HA exercise, and how data are presented to users, are both important determinants of whether HA are seen by policy-makers and others as a valuable public resource. Timely, good-quality and widely and easily accessible products, tailored to the various audiences (within and outside government) that demand them can strengthen the relevance and legitimacy of HA. Conversely, when information is presented with excessive lags, communicated poorly and/or includes key data gaps, then HA may lack impact or be ignored altogether.

This highlights an important link between the quality of the HA production process and the quality of the information presented to users. Data limitations, and/or limited technical capacity to precisely classify health expenditure can lead to HA products with limited informational content and limited policy utility.

There are many potential users of HA information. This includes a set of experts in the ministry of health and the health sector, plus academics and technical staff within development partner organizations, who may be familiar with the SHA 2011 methodology. It is also likely to include non-experts, such as other line ministry staff, members of parliament and the public at large, who will usually not be familiar with the intricacies of SHA 2011 *(1)*.

Perhaps the rest of the discussion of this domain should focus on audiences, including the way that HA information is presented to audiences, and how audiences use this information make decisions.

4.1. HA products

There are several potential products that result from the HA process. Raw numerical outputs are included in databases. These include standard two-dimensional tables that cross-tabulate expenditure across relevant SHA 2011 classifications (e.g. showing how resources flow from financing schemes (HF) to providers (HP)). These standard tables are useful for creating consistent aggregate totals and subtotals across HA tables and for a standardized presentation of results across countries. These raw HA data feed into the GHED, which is a globally accessible time series database of major spending classifications for all countries.[7] GHED includes metadata that complement the data and give explanations about its quality.

For many countries, the shortest turnaround time for compiling HA is 1-2 years. However, the publication of HA can often involve longer delays (shorter delays are possible but less common). Critically the longer the delay in publishing HA data the less informative users are likely to find the information for decision-making.

In addition to raw data, various forms of briefing information can be compiled to explain the observations and trends in HA and interpret them for various audiences. Unlike the presentation of numerical data, these briefs are not standardized and can be tuned to the needs of the various audiences. This may involve highly technical reports and a suite of less technical products, such as briefs, fact sheets and infographics. Knowing what types of audiences to target, their information needs, and their technical capacity to absorb HA information, is an important part of stakeholder engagement.

Considering the varying informational needs of users has some clear potential benefits for HA institutionalization (*1, 8)*. Virtuous cycles can be created in which well-targeted information raises awareness of HA, resulting in rising (and ongoing) demands for quality HA information. This, in turn, can spur greater investment in institutionalizing and improving the HA production process.

[7] Data on GHED is produced by HAPT and is also gathered from Joint Health Account Questionnaires (JHAQ; created by WHO, the OECD and Eurostat) and Health Accounts Questionnaires (based on JHAQ).

Guiding questions: 4.1 HA products

- **Database**
  - What is the year of the latest HA data?
  - For your latest publication, which classifications, cross-classifications and indicators are included?
  - For your latest publication, did you produce HA at the subnational level?
  - How frequently do you update the database?
  - Do you publish metadata and what are included in metadata?

- **Reports & policy briefs**
  - Do you produce a report and policy brief for each exercise of data collection?
  - Who is the target audience for the HA report and policy brief?
  - Do the reports/briefs combine HA information with other information (e.g. disease burden, macro-fiscal data)?

- **Are there any other materials used to communicate the results of HA? (Such as speeches, newspaper articles, flashcards, flyers, tweets, etc.)**

4.2. Methods of dissemination

In addition to calibrating products and messages to different audiences, ensuring that HA outputs (including outputs from previous exercises of HA) are released in a timely manner is fundamental to the effective communication of results.

Critically, the longer the delay in publishing HA data the less informative users are likely to find the information for decision-making. Timeliness can be enhanced by minimizing the delay between the HA year and the year of publication. Administrative lags and approval bottlenecks for releasing HA end-products should also be minimized.

Dissemination methods should aim to ensure that HA information is widely accessible. Various options exist to broaden the reach of HA end-products, including the publication of databases and published material on ministry websites, media, social media, town hall meetings and workshops.

Guiding questions: 4.2 HA methods of dissemination

- **What is the approval process for dissemination of the HA products?**

- **What HA-related products are available on public websites (and for which years)?**

Year	Database	Report	Policy brief	Any related products

- **For your latest HA results, was there a specific event held to release the products? Please describe the organizer, the scale, the audience and the focus.**

- **For your latest exercise of HA dissemination, is there any form of media coverage (newspaper articles, publications on social media, radio, etc.)? Please provide the key details/references.**

An active approach to public dissemination of HA outputs will likely have many benefits. Most notably, greater citizen engagement in HA can help create a more informed citizenry. This, in turn, can help promote a more participatory, inclusive, and accountable model of health governance. It can also create more avenues for stakeholder feedback to improve performance.

4.3. Use of HA data

Stewardship of health systems is improved when the outputs of the HA process facilitate better decision-making. A key advantage of the SHA 2011 framework is that it can provide actionable data to directly contribute to the budget planning process and broader system reforms and strategies of priority programmes. Expenditure indicators are helpful for monitoring the performance of health systems and for promoting transparency and accountability.

However, HA information cannot trigger actions if no one pays attention to it, even if it is presented succinctly and clearly. Thus, a critical element of the institutionalization process is the extent to which stakeholders use HA to monitor and evaluate health system performance, shape policy dialogue and frame research and advocacy. This includes stakeholders within government (including the legislature, executive and central ministries, as well as within the ministry of health) and outside government (development partners, civil society, academia and think tanks).

Numerous potential benefits stem from strengthening the use of HA outputs. Integrating HA into critical aspects of routine health governance, such as the policy deliberations of the ministry of health and the annual planning and budgeting process, can strengthen the evidence base for decision-making and deepen insights into the contextual factors shaping HA. Improving the use of countries' HA data by external stakeholders can improve the targeting of development assistance.

Guiding questions: 4.3 Use of HA data

- **Does the HA team track the use of HA data, users' feedback and needs? If so, how?**
- **Were data from the last exercise of HA used in planning and budgeting processes, monitoring and evaluation, or policy development? Please elaborate.**
- **What HA information is most used and needed in monitoring and evaluation frameworks for the health sector?**
- **Do HA data contribute to policy development? If yes, what types of HA information were most useful in shaping policy?**
- **Were data from the last exercise of HA used for donor reports? Please elaborate on which indicators and which donors.**
- **For what reasons (if any) were HA data not used by an entity that demanded it? Provide detail on ways in which HA data did not meet a users' needs.**

PART C

Summary and next steps

The framework presented in this report should help to assess where a given country sits regarding their HA institutionalization and the areas for improvement.

Importantly, however, the assessment should not be seen as definitive. It sets out a standard set of relevant questions regarding institutionalization that can be widely applied. It also provides a basis for experimentation; for best results, the questions used for assessment should be adjusted to reflect countries' specific contexts. This can help provide a clearer picture of the progress and challenges within each country. Countries and partners are encouraged to tailor the questions presented in the framework when assessing HA institutionalization. Experimentation can also occur with different summary metrics.

As countries undertake the analysis, they are encouraged to share their results with WHO and peers. By generating evidence and comparing and contrasting experiences, lessons can be learned about what practices can best support HA in countries that are beginning their journey or that may be regressing. Repeated application of the assessment framework can help reveal changes over time.

The initial consultation process that gave rise to the framework in this report revealed some high-level insights for different country groupings (see Annex 4). Four broad types of countries are identified based on the maturity of the institutionalization process: a. countries that have not started the HA production; b. countries beginning their HA journey; c. countries that have produced exercises of HA but not in a systematized way; and d. countries that produce HA regularly. Countries in these groupings face different challenges and should therefore have different focuses. Notably, in no country is HA thoroughly institutionalized – even in countries that have the most mature production processes there can be issues with institutionalizing its uses. Institutionalization is an ongoing process, not an end-point, which requires continuing investment and effort.

WHO and global partners support the maturity of HA institutionalization. They work closely with the Member States to produce reliable, comparable, policy-relevant and up-to-date health expenditure data. WHO and global partners also provide a platform for sharing and disseminating cross-country experiences. However, the considerable outstanding challenges impeding the institutionalization of HA suggest that more work is needed.

Further, through their demands for HA data and their investments in technical support, development partners such as WHO, World Bank and International Monetary Fund help provide the impetus to improve HA practice within countries. The results of the HA institutionalization frameworks can thus be leveraged to ensure that any investments are targeted at overcoming the most binding constraints.

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Annex 1. A potted history of health accounts

The development of health accounts (HA) first centres on the United States of America, which initiated the systematic measurement of health spending information for domestic purposes. There were challenges instituting the process, and the sophistication of the accounting framework and techniques for capturing data had to evolve as demands for and use of HA data increased. Notably, this included increased demands for cross-country comparisons. These developments laid the groundwork for a globally standardized framework for measuring HA that could be applied to all countries, which we now know as the System of Health Accounts (2011). This potted history draws from the work of Fetter (2006) and supporting documentation *(1)*.

The first health accounts efforts

The earliest documented efforts to measure health expenditure came from the private sector in the United States. In 1926, the national convention of the American Medical Association discussed ways to improve Americans' access to medical care by expanding availability while lowering costs. The Committee on the Costs of Medical Care (CCMC) was established. It published the cost of medical care expressed as a proportion of the "money income of the country". In what would become an antecedent of key health account classifications, the CCMC divided health expenditures into four groups of payers: patients, government, philanthropy and industry.

The availability of the CCMC-produced HA provided a new policy-relevant lens on the health sector and a prototype for the matrix presentation of health expenditure. In 1932, Americans spent, in aggregate, twice as much on tobacco, toiletries and recreation – and nearly three times as much on automobiles and other travel – as on health services. Patients' out-of-pocket expenditures accounted for 79% of health expenditures.

This early monitoring health expenditure in the United States illustrates the challenges of initiating and institutionalizing HA, even within a high-income setting. The CCMC, which was initially responsible for collecting and analysing HA information, was subject to considerable change as the United States Government underwent organizational flux. In the 1930s, members of the CCMC were absorbed into government agencies charged with broader social welfare accounting, which would result in health expenditure measurement functions sitting under the Federal Security Agency – the predecessor to the Department of Health, Education and Welfare.

Fragmentation and overlap also occurred in data collection. During the 1940s, the Bureau of Research and Statistics, the national statistical agency, was generally responsible for collecting and analysing data of national importance. This included the costs of health and disability insurance, which were first published in the Social Security Bulletin in 1937. At the same time, however, specialists in various individual agencies performed their own analyses, including on health expenditure.

To gain better insights into the effectiveness of health and other social policies in the United States, in 1937, the Bureau of Research and Statistics launched an annual survey of social security provision in other countries. These surveys were the first attempts at establishing cross-country uniformity in the compilation and presentation of health expenditures.

The 1950s marked a watershed for the introduction institutionalization of HA and of measuring economic progress more generally. In 1953 Health, Education and Welfare obtained full United States cabinet status, and the first official estimate of the total proportion of gross national product spent on social welfare (including health) was produced in the same year. However, the quality of estimates was hampered by issues with establishing the boundaries of the health sector and the need to compile expenditure information from various public agencies that had unique ways of classifying spending and fiscal years.

In 1964 the National Health Expenditures (NHE) was established. The NHE built on the basic CCMC model, modified for health service payment and delivery changes. It also harmonized private and public expenditures and reconciled differences in fiscal years and medical service categories. The NHE became a useful annual time series of health expenditures unavailable elsewhere. Eventually, the NHE constructed back-estimates of health expenditures to create a time series beginning in 1929.

Over time, the demand for health expenditure data shifted from identifying the amount spent on health (and its share of national income) to whether government, businesses and individuals were getting value for money. Evaluating such questions required the combination of spending data with information on the provision of health care services and outcomes. This shift precipitated a growing political interest in the utility of HA as a decision-making tool, which further embedded HA into the institutional fabric of the United States Government.

International comparisons of health expenditures

While a standardized process for collecting and reporting data on health expenditures had evolved in the United States, this was not being replicated elsewhere. A landmark 1981 study compared health expenditure in 10 industrialized market economies using data from the early 1960s to 1976–77 *(2)*. Following the laborious compilation of data, the study found a strong correlation between a country's level of income and health's share of GDP. It also identified several epidemiological and economic drivers of spending growth. Most notably, the author concluded the study with a plea for the harmonization of health data: "the time is overdue for international agreement on data collection about health expenditures. It is foolish to continue to rely on the initiative of individuals" – and some practical suggestions as to how this might be undertaken.

No progress had yet been made on the WHO's call several years earlier to standardize the collection and use of health expenditure information. This stemmed from a 1977 WHO-convened study group on the financing of health services, which reviewed the landscape of ad hoc country health expenditure. In addition to calls for regular data submission and publication, the report advocated for an agreed chart of accounts to be drawn up to suit all countries, including developing countries.

A common framework for tracking health spending in countries

In 1998 the United States hosted a conference to discuss the future directions of National Health Accounting. Presentations were given by the World Bank, the European Union, USAID and the Organisation for Economic Co-operation and Development (OECD) on the merit of a standard instrument to compare national health systems globally. Some time, however, would elapse until a common toolbox emerged.

In 2000, OECD recognized that health was becoming an important industry that needed a core set of financial data to meet the needs of analysts and policy-makers. OECD produced the System of Health Accounts (SHA 1.0) *(3)*. This represented the first version of a manual to help standardize a set of comprehensive, consistent and flexible health accounts. The methodology introduced the triaxial system for recording health expenditure, focused on final consumption, which accounts for the fact that what has been consumed has also been produced and funded. It also explicitly linked health accounts with SHA to create an integrated, cohesive and internally consistent approach to measuring the spending activities in the health sector.

In 2011 a newer version of the SHA framework was produced by the OECD, Eurostat, and WHO (SHA2011) *(4)*. This followed an extensive and wide-reaching consultation process. The SHA 2011 framework builds on the original SHA 1.0 methodology, maintaining its triaxial foundations. However, it rectifies some of the shortcomings in the initial manual and considers new developments in health care and financing. SHA 2011 has become the global standard for producing HA. Today WHO published HA data for around 190 countries in the Global Health Expenditure Database.

Discussions remain ongoing among key stakeholders in Member States and partners for improving the SHA framework. This includes data, analysis, information and knowledge to inform decision-making at the national level.

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Annex 2. Approach for developing the HA institutionalization framework

The World Health Organization initiated a consultative process to develop a framework that to support the assessment of countries' progress towards HA institutionalization and generate evidence for timely support.

Building on previous work, the objectives of the assignment were to:

1. **Review the literature and documents on past and ongoing efforts to institutionalize HA in countries.** The literature review examined a. the first health accounts efforts and evolution; b. work developed by partners on HA institutionalization, and c. Internal documents on HA institutionalization. It was conducted between February and March 2022. The literature and documents review was used to produce Annex 1, the interview questions (Annex 3) and the framework references (Part A and B).

2. **Conduct in-depth interviews with global experts to gather country and regional experience to identify the key domains of HA institutionalization.** The in-depth interviews with global experts were online interviews conducted separately by Dr Angelique Kanyange, a senior short-term consultant to the World Health Organization. The criteria for selecting the participants were a. long-term experience in HA, b. experience in HA institutionalization in at least one WHO region and/or c. leading institutional-technical assistance in HA at regional and/or country levels. The interviewees included health accounts experts, policy makers, and development partner agencies supporting the efforts in producing HA reports (Annex 3).

3. **Develop a framework and an assessment for tracking countries' progress towards HA institutionalization.** The framework was developed based on the literature and documents review and in-depth interviews with global experts. The interview questions and findings include the following elements: definition of HA institutionalization, narrative, missing elements for HA Institutionalization, success factors, challenges, and best practices and recommendations. These elements enabled emerging themes around key domains and their relationships, and the current framework was produced to track countries' progress and propose expedited and informed support to countries. The framework guides countries to identify gaps that need further efforts through a set of suggested questions; however, it leaves sufficient flexibility for countries to tailor based on their context (Part B). In addition, a country categorization of challenges and observations was produced depending on HA institutionalization development (Annex 4).

4. **Review and pilot the assessment for tracking countries' progress towards HA institutionalization.** The framework was reviewed by the regional offices, international experts and country health accounts teams. The framework was also presented in regional meetings. The framework was piloted in more than ten countries in WPRO, AFRO, EURO and SEARO between 2022-2023.

Annex 3. Interview questions

1. Which countries have you worked in and/or do you intend to support? What are the countries you have evaluated in relation with HA?

2. Have you been involved in supporting the institutionalization of HA? If yes, in what areas?

3. The definition of HA institutionalization often refers to a country's production of HA data on a regular basis and the use of that evidence for policy-making. Based on your experience, is this the general understanding of the concept? What else do we need to consider?

4. As countries work towards more accountability and evidence-based decision-making, do you think it would be helpful to support HA institutionalization using indicators that would signal areas of challenge?

5. Several challenges have been documented, from governance, to production, dissemination, and translation of data into policy; below, we would love to learn from you:
   a. In your view, who drives the HA agenda in developing countries? And why? What do you think can be done to improve ownership?
   b. There has been evidence of a lack of leadership and prioritization of HA; when there is commitment, funding does not follow. What can be the indicators to track progress on country governance, ownership, and funding for HA?
   c. In terms of governance, what are the legal, institutional, and organizational arrangements needed to support further HA institutionalization? What considerations are behind each decision in countries? Can you suggest the best indicators for complete institutionalization?
   d. One of the key challenges has been the lack of capacity: at the individual (staff turnover) and institutional levels (lack of attention and legal and institutional frameworks). Is this challenge still a real issue? What indicators can countries and global players use to assess progress on capacity?
   e. The production of HA has continued to be done through expensive surveys that stakeholders qualify as outdated, in most developing countries, without integration in other vital statistics or the use of information technologies. Is this the case according to your experience? What do you think should be done to address those challenges?
   f. Data shows that some policy-makers in developing countries have questioned HA data quality, completeness, and accuracy. What do you think of this challenge, and what can be done to improve further HA data production?
   g. HA dissemination strategies have been defined as extremely limited; reports are said to be sitting on the shelves. Do you think HA has received the proper dissemination attention, has used the best processes, and has reached targeted audiences? What can be done to improve those limitations further?
   h. Previous work shows that translating HA data into policy is sometimes absent or incomplete. Did you have the same observation? What do you think needs to be done to improve the linkages between HA production and policy-making?

6. Are the questions above sufficient to provide a complete framework to understand countries' HA institutionalization maturity?

7. Is there anything left out that should be part of measuring countries' progress towards full institutionalization of HA? If yes, please elaborate more.

8. Do you have documents on HA that you may share or work you may know about?

9. Would you be willing to be called again if there is a need for further clarification?

Annex 4. Challenges and observations based on the interview with experts

Countries that have not started HA production

This is particularly the case in fragile, conflict-affected, and new states where weak institutions, severely limited technical and financial capacity and/or a challenging security environment preclude the preparation of health accounts (HA). In such countries, which may include places where HA was once undertaken, the priorities of governments and donors may centre on sectors other than health. Governments may also have limited focus on equity and universal health coverage, or may lack interest in promoting transparency.

Considerable external support from global and regional development partners will be required to support countries where HA production is not occurring and basic capacity is not in place. Externally funded consultants will be needed to undertake early work collecting information, preparing reports and disseminating results. Activities may be housed within the ministry of health or outside the government if absorptive issues are too great. Collaboration between external partners and national players – potentially a national champion – from the outset is critical to begin the process of country ownership.

Countries beginning their HA journey

In many low- and middle-income countries, there remains an ongoing dependence on donors for HA due to lack of local technical and financial capacity – with local or international consultants funded by development partners and data collection relying on periodic donor-funded surveys. While this may lead to several exercises of HA, institutionalization is lacking. This can be for many reasons, including lack of an official mandate and budget for HA as well as disconnection from government information systems. It may also be caused by perceptions that HA is a donor-driven initiative for global comparisons rather than a policy tool for improving transparency, accountability and responsiveness to citizens. Such perceptions can create a negative feedback loop: limited domestic demand for HA production constrains investment in HA production and adversely impacts the quality and usefulness of the outputs. Moreover, the limited integration between external and national systems means that little legacy is left in terms of local capacity-building, even after a few exercises of HA.

Ideally, HA production and dissemination should be a country-led routine exercise based on well-functioning information systems, and not be dependent on external assistance and/or expensive ad hoc surveys. Respondents suggested that with strong political will, countries have shown it is possible to shift to a more sustainable HA footing. Key to the institutionalization process is a well-developed organizational structure, technical and institutional capacity, and clear integration of HA into the existing data systems of a country (e.g. (integrated) financial management information systems).

For countries to transition to a sustainable country-led HA model will require sustained support and commitment from the donor community. Deep collaboration and technical and financial resources can help countries build indigenous organizational structures and the requisite technical and institutional capacity. A progression model could be rolled out to provide a blueprint for action. Development partners can also provide support that helps promote HA expertise as an attractive career pathway to recruit and retain trained human resources. Additionally, through their demands for HA information, partners such as the WHO, Global Health Initiatives, and other consumers of statistical information (e.g. World Bank and International Monetary Fund) can help drive positive change. External demands for information can help instigate investments in strengthening data systems and ensure that HA production is precise, reliable and produces high-quality outputs.

Countries that have produced HA but not in a systematized way

Countries may have shown political will for HA and even developed several exercises of HA using national systems. However, for various reasons, the process is not routine and systematized. This can involve countries developing their own measurement approach, distinct from SHA 2011. It can involve fragmented and incomplete approaches to gathering information, with a lack of engagement across key stakeholders (such as the private sector) and/or ad hoc and non-routine ways of collecting information.

Fragmentation can be exacerbated by parallel administrative and financing processes put in place by development partners (particularly around vertical disease control programmes). In some African countries, it has been observed that a lack of organization has left HA production floating between the ministry of health, which is not well equipped to undertake accounting tasks, and the national statistics office, which does not have sufficient knowledge of health system operation, and other organizations, which view HA as a perfunctory reporting exercise. Backsliding political will and lukewarm commitment to consistency can also disrupt HA production when there are no legal obligations to prepare HA routinely.

Countries may have produced several exercises of HA and later stopped HA production. Several Latin American countries were mentioned to be in this situation. Such countries often have underlying data systems and do not need financial support but instead need to commit to meeting global and regional standards. Supporting these countries includes encouraging leaders to demand HA data and initiate the process themselves – this will encourage commitment towards HA institutionalization. This can be done by global and regional support, experience sharing and horizontal learning to sustain the progress and improve data quality. It is also important to engage countries in routine data validation processes by working with WHO Global Health Expenditure Database publication to ensure the independence of data production from political influence.

Countries that produce HA regularly

Many higher-income countries have mature HA institutions and regularly produce HA exercises supported by well-established information systems. Interviews with experts reveal that in many instances where HA is more institutionalized, countries have realized the necessity of producing HA for policy-making.[8]

However, even in countries that produce HA regularly, there is variation in the extent to which HA is used. In some places, HA is embedded within planning and budgeting and is supported by well-established information systems. However, HA data may still not be routinely integrated into key decision-making processes; for example, being absent from the deliberations that occur within legislatures and executives that are key to shaping health policies and reform. Like other countries, private sector engagement can be a persistent challenge. At the same time, HA may be viewed within the health sector simply as a reporting requirement to international statistical agencies (such as the Organisation for Economic Co-operation and Development or Eurostat) rather than a policy tool.[9]

For countries in which HA production is more institutionalized, there may be many reasons for this lack of engagement. It can include a lack of understanding of HA and of the potential benefits of HA; both of which result in shortfalls in demand for HA. It may also reflect issues of quality of HA. Finding ways to improve engagement with HA and place it on the policy agenda should therefore be a focus of future institutionalization efforts. Improving awareness should help stimulate demand for HA outputs – a key step towards embedding outputs within key routine governance processes. This may include more targeted stakeholder engagement, tailored briefs and other products that build overall awareness of and ownership over HA.

[1] This necessity was expressed either by the government (Thailand) or private citizens (USA – see Annex 1); in both cases individual champions were necessary to push towards institutionalization.

[2] Eurostat is the statistical office of the European Union based in Luxembourg and publishing reports official harmonized for the Euro Zone.

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