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Tracking Resource Flows for RMNCH in Asia-Pacific Countries

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#CD2015

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Financing Flows

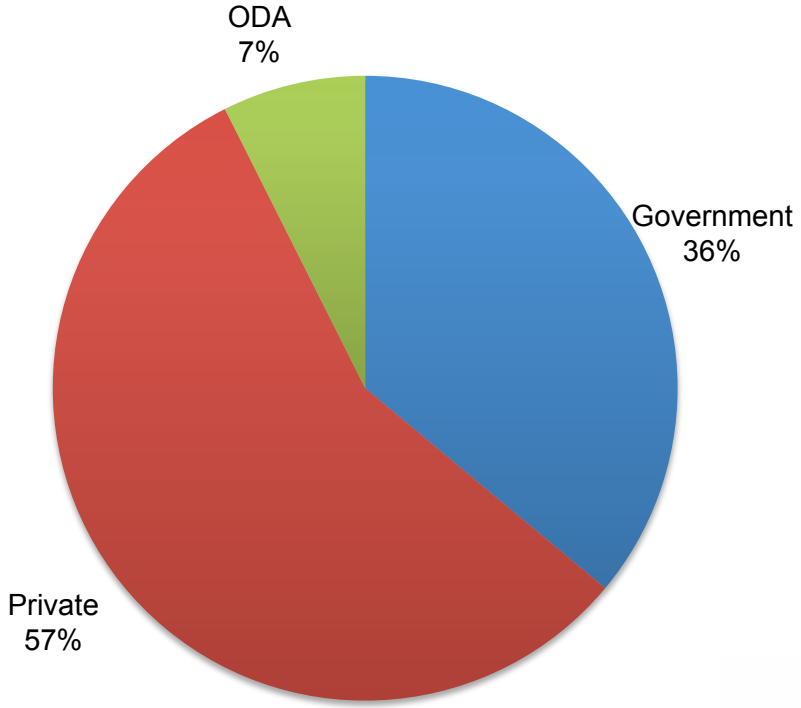
- Financing matters for RMNCH
  - How much?
  - By whom?
  - For what?

- COIA

Recommendation 4

Resource tracking: By 2015, all 75 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) **total health expenditure by financing source**, per capita; and (ii) **total reproductive, maternal, newborn and child health expenditure by financing source**, per capita.

Financing of health services, low income countries (2009)



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Tracking domestic flows

Easy to say, but hard in practice

- Few priority countries have reliable estimates of all domestic spending flows
- Fewer have systems to routinely track expenditures
- Almost none have systems to track RMNCH spending routinely
- Large number of MNCH cost studies done, but ad-hoc and lacking in comparability
- Often ignore bulk of spending in non-MNCH programs

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Asia-Pacific Regional Pilot Study

- APNHAN-OECD Regional Health Accounts Experts
  - Annual collection from 20 countries of HA estimates using SHA
- Pilot survey
  - Check feasibility of piggy-backing RMNCH spending
  - Use low-cost methods to estimate RMNCH spending from annual NHA aggregates

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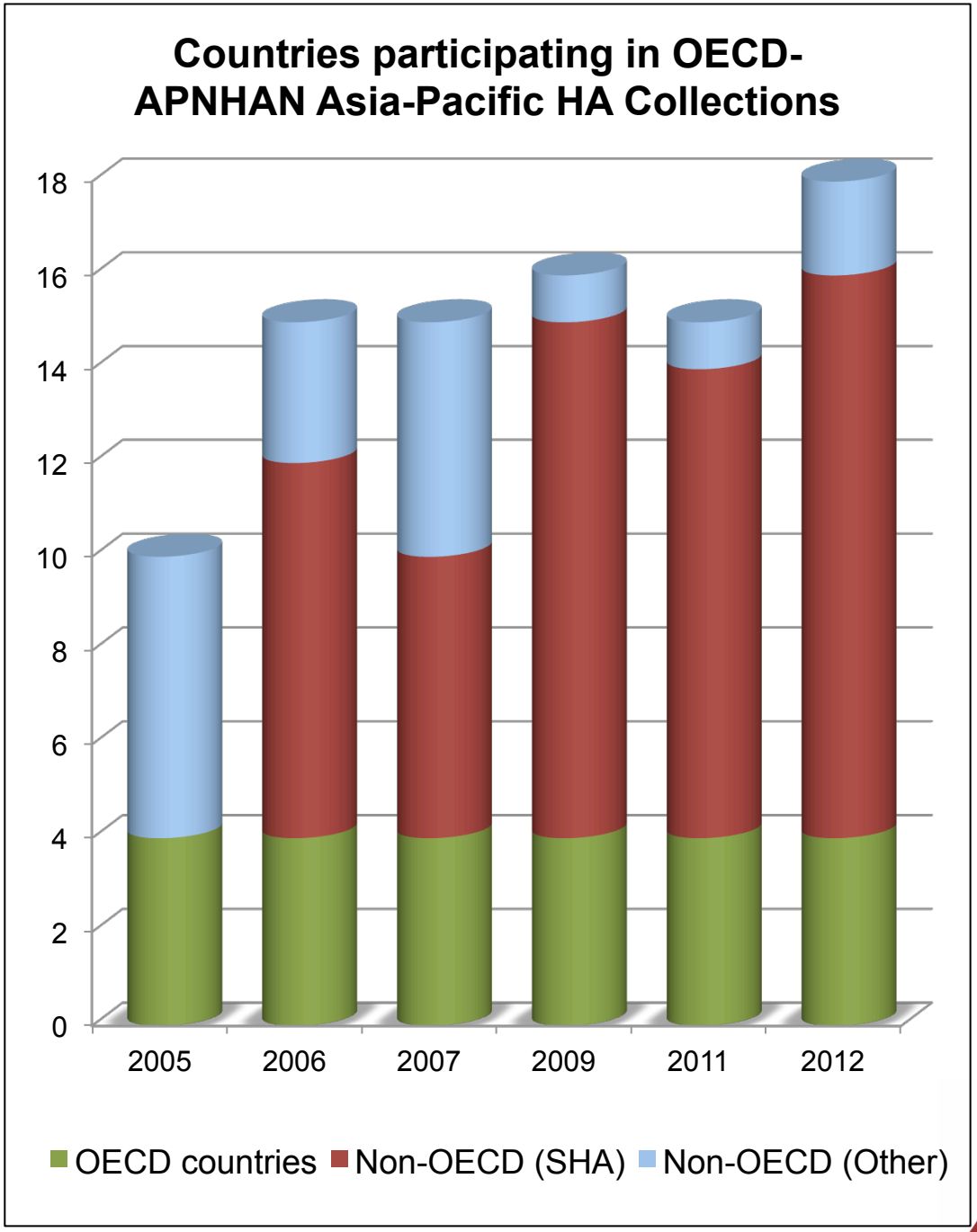
OECD/APNHAN HA Collection

- Increasing number of countries in region participating over time
  - Inc. AFG, BAN, CHN, IDN, IND, MMR, MON, NEP, PAK, PHI, VNM
  - Exc. KHM, LAO, PRK, PNG, SLB, TJK, TKN, UZB
- Increasing use of SHA as reporting framework
- Reporting either annually or semi-annually



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Proposed Methodology

Inpatient spending on RMNCH

- SHA accounts > Inpatient expenditure
- RMNCH share of admissions/days

Outpatient spending on RMNCH

- SHA accounts > Outpatient expenditure
- RMNCH share of outpatient visits

Preventive spending on RMNCH

- SHA accounts > Preventive expenditure
- Analysis of RMNCH shares in each program

RMNCH Expenditures

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Findings I
Feasibility

- Most countries could report SHA aggregates routinely, but:
  - Did not have the needed secondary data for RMNCH estimation
    - e.g., survey data on RMNCH expenditures by households
  - Or did not know how to find it
  - Or did not know how to analyze it
- In-depth assessment found that the problem of no data was not so great as reported
  - Real problem is technical capacity at NHA agencies – limited experience in estimation
  - Technical capacity weakest in priority countries

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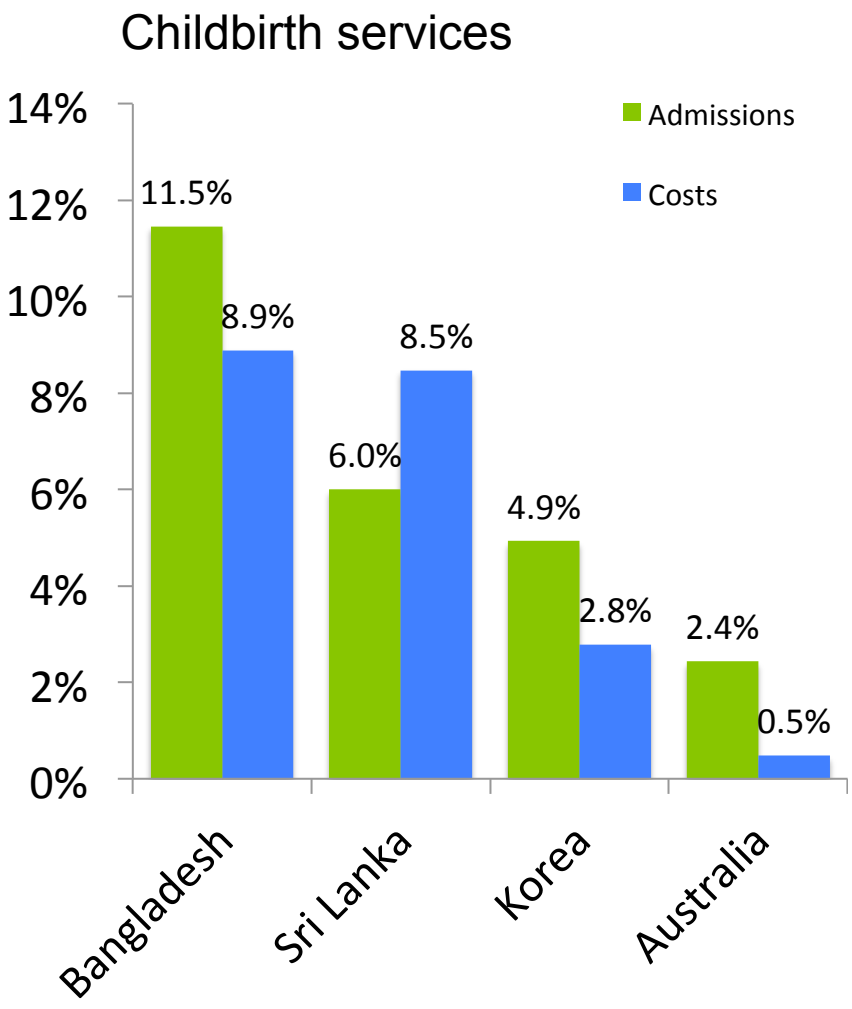
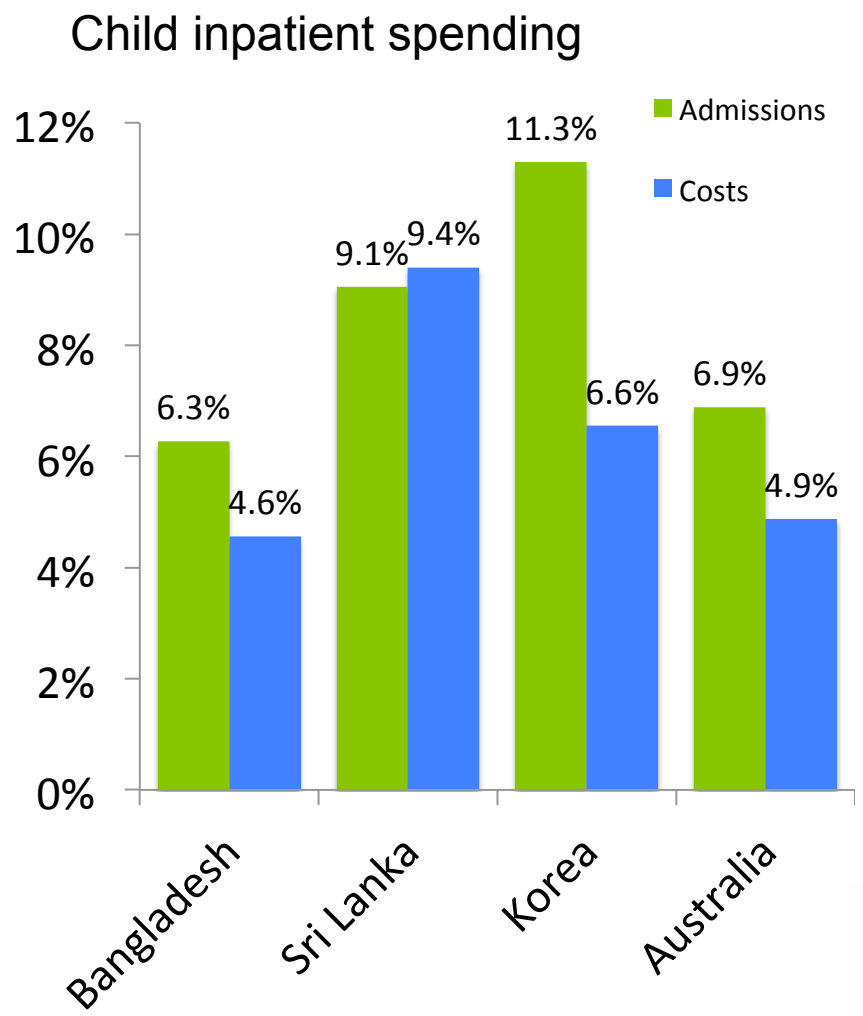
Findings II

Validation of methods





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Bangladesh Health Accounts

Table 1: Current healthcare expenditures by major financing source and type of provider, Bangladesh 2006/2007 (Taka billions)

Provider	MOHFW	Other public	House-holds	Other private	Rest of the World	Total
General administration	0.6	0.0	0.0	0.1	0.0	0.7
Hospitals	17.1	0.4	13.7	1.1	6.0	38.3
Ambulatory providers	11.6	0.0	17.9	0.9	4.5	34.9
Pharmacies and other medicine retailers	0.0	0.0	65.5	0.6	0.0	66.1
Other medical goods suppliers	0.0	0.0	3.0	0.0	0.0	3.0
Public health programs	1.8	0.0	0.0	0.4	1.8	4.0
Other providers	0.8	0.0	0.0	0.7	0.0	1.5
Total	**31.9**	**0.4**	**100.1**	**3.7**	**12.4**	**148.5**

Source: MOHFW Bangladesh NHA 2007

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MNCH Spending - Govt. Facilities

Table 1: Current healthcare expenditures by major financing source and type of provider, Bangladesh 2006/2007 (Taka billions)

Provider	MOHFW	Other public	House-holds	Other private	Rest of the World	Total
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Ambulatory providers	11.6	0.0	17.9	0.9	4.5	34.9
Pharmacies and other medicine retailers	0.0	0.0	65.5	0.6	0.0	66.1
Other medical goods suppliers	0.0	0.0	3.0	0.0	0.0	3.0
Public health programs	1.8	0.0	0.0	0.7	1.8	4.3
Other providers	0.8	0.0	0.0	0.0	0.0	1.5
Total	**31.9**	**0.4**	100.1	3.7	12.4	148.5

Existing MOHFW data

- Previous patient sample surveys of age, sex, condition, treatment inputs of patients

Data collection (ADB RETA-6515)

- Facility cost study to obtain costs of inputs and services
- Combined with patient data to estimates costs by all age/sex and disease (ICD-10)

Source: MOHFW Bangladesh NHA 2007

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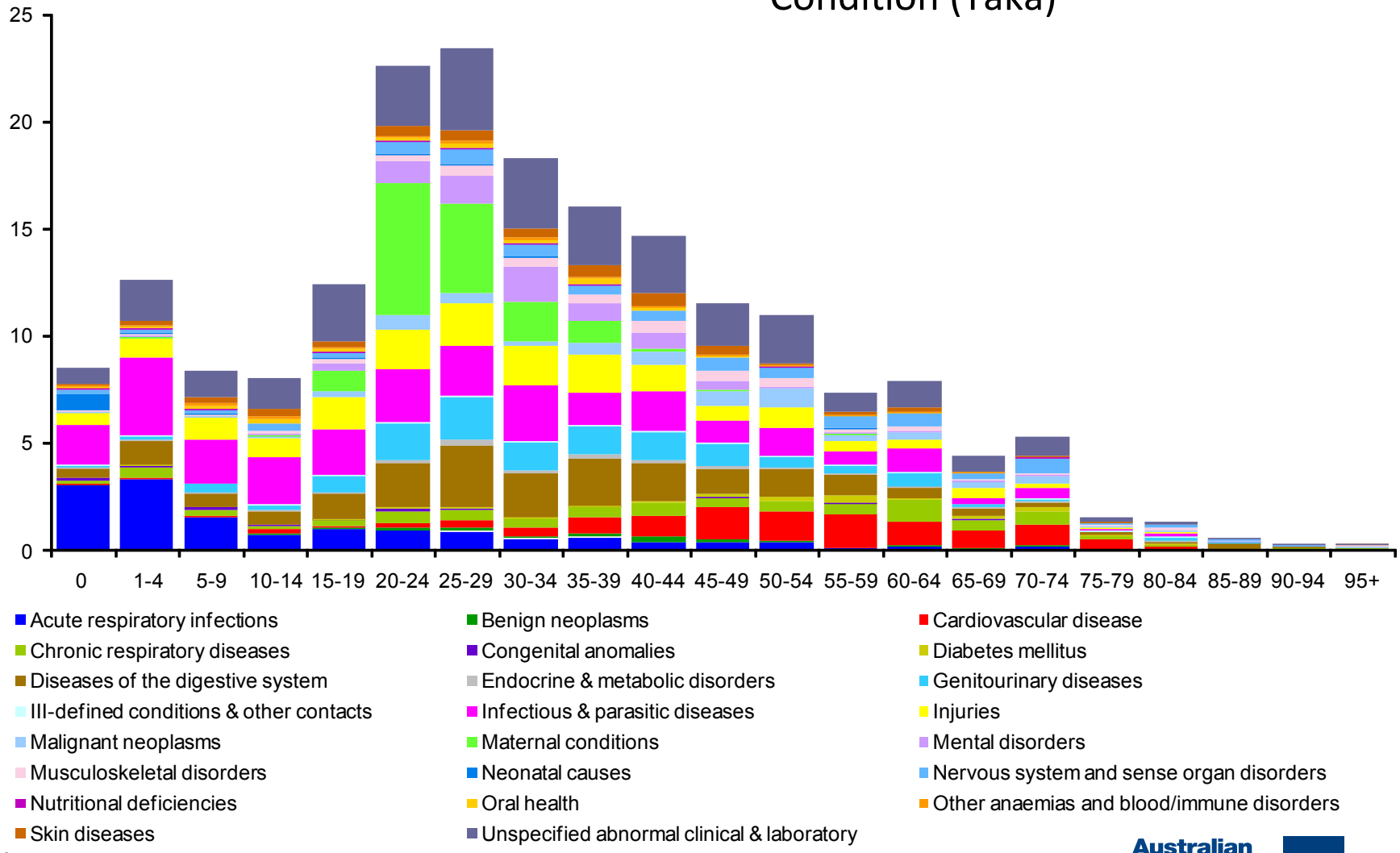
Bangladesh 2007

– MOHFW Facility Expenditure/Capita by Age and Condition (Taka)



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MNCH Spending – Hospital OOPE

Table 1: Current healthcare expenditures by major financing source and type of provider, Bangladesh 2006/2007 (Taka billions)

Provider	MOHFW	Other public	House-holds	Other private	Rest of the World	Total
General administration	0.6	0.0	0.0	0.1	0.0	0.7
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Pharmacies and other medicine retailers	0.0	0.0	65.5	0.6	0.0	66.1
Other medical goods suppliers	0.0	0.0	3.0	0.0	0.0	3.0
Public health programs	1.8	0.0	0.0	0.0	1.8	4.0
Other providers	0.8	0.0	0.0	0.0	0.0	1.5
Total	**31.9**	0.4	100.1	2.7	12.4	148.5

Existing MOHFW data

- National survey data on household spending, but no details of spending at government facilities

Data collection (ADB RETA-6515)

- Patient exit survey focusing on why money was spent and on what

Source: MOHFW Bangladesh NHA 2007

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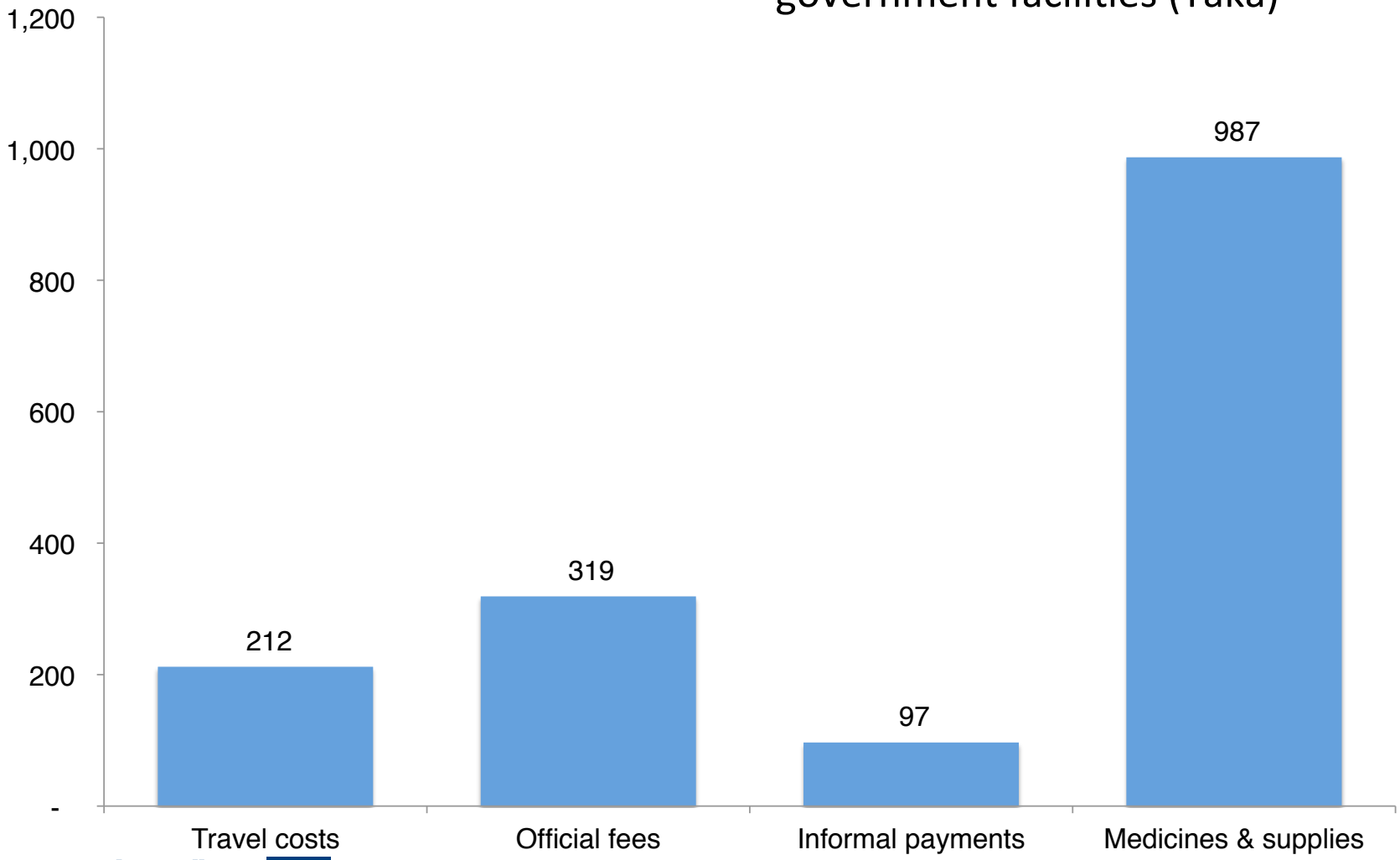
Bangladesh 2011

– Average payments reported by mothers delivering at government facilities (Taka)



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MNCH Spending - Pharmacies

Table 1: Current healthcare expenditures by major financing source and type of provider, Bangladesh 2006/2007 (Taka billions)

Provider	MOHFW	Other public	House-holds	Other private	Rest of the World	Total
General administration	0.6	0.0	0.0	0.1	0.0	0.7
Hospitals	17.1	0.4	13.7	1.1	6.0	38.3
Ambulatory providers	11.6	0.0	17.9	0.9	4.5	34.9
Pharmacies and other medicine retailers	0.0	0.0	65.5	0.6	0.0	66.1
Other medical goods suppliers	0.0	0.0	3.0	0.0	0.0	3.0
Public health programs	[illegible]	[illegible]	[illegible]	0.4	1.8	4.0
Other providers	0.8	0.0	0.0	0.7	0.0	1.5
Total	[illegible]	0.4	[illegible]	**3.7**	**12.4**	**148.5**

Existing MOHFW data

- National sample survey of pharmacy patients – age/sex/complaints/medicines

Data collection (ADB RETA-6515)

- IMS-Health national sales data by molecule
- Combined with sample survey data to estimate pharmacy sales by disease

Source: MOHFW Bangladesh NHA 2007

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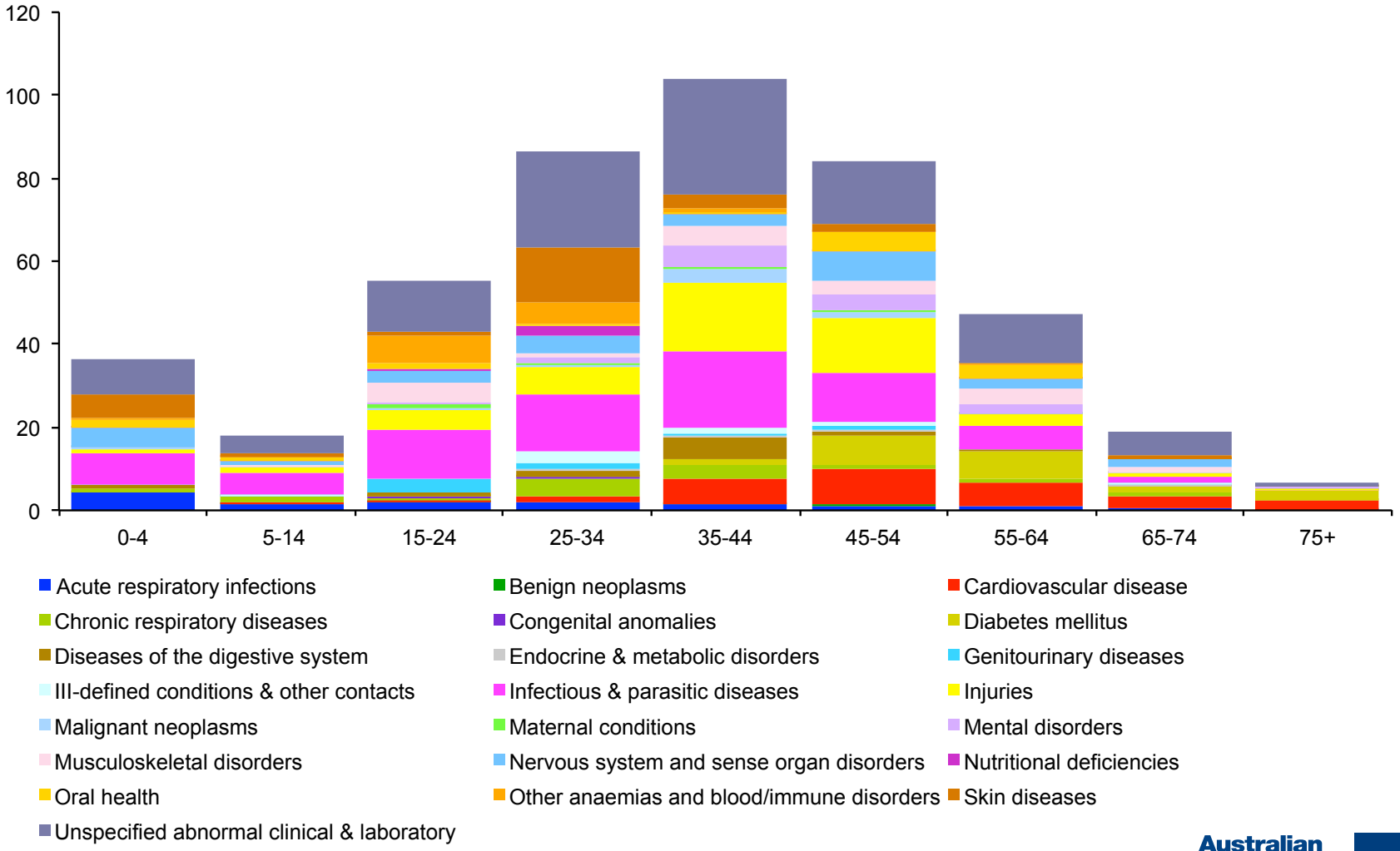
Bangladesh 2007

– Pharmacy Expenditures Per Capita by Age and Condition (Taka)



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Bangladesh 2007

– MNCH Expenditures

Total MNCH Patient Expenditures (FY 2007)

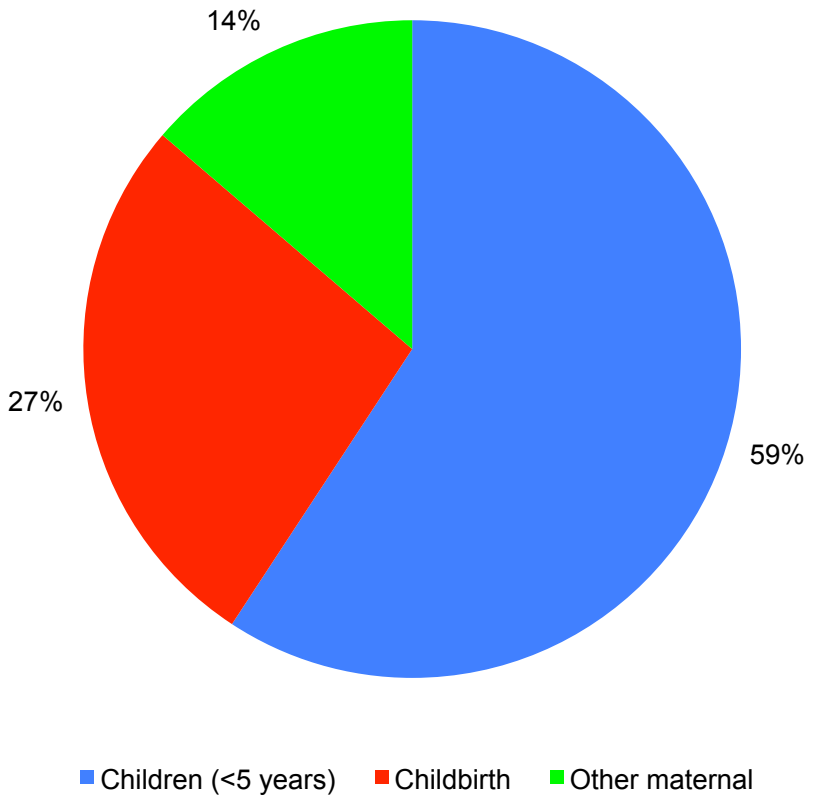
- Tk 17.3 billion
- Tk 121 per capita
- 12% of current health spending

Composition

- Children 59%
- Childbirth 28%
- Other maternal 14%

MOHFW share of MNCH financing

- 28%



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Bangladesh 2007

– Who pays for what?

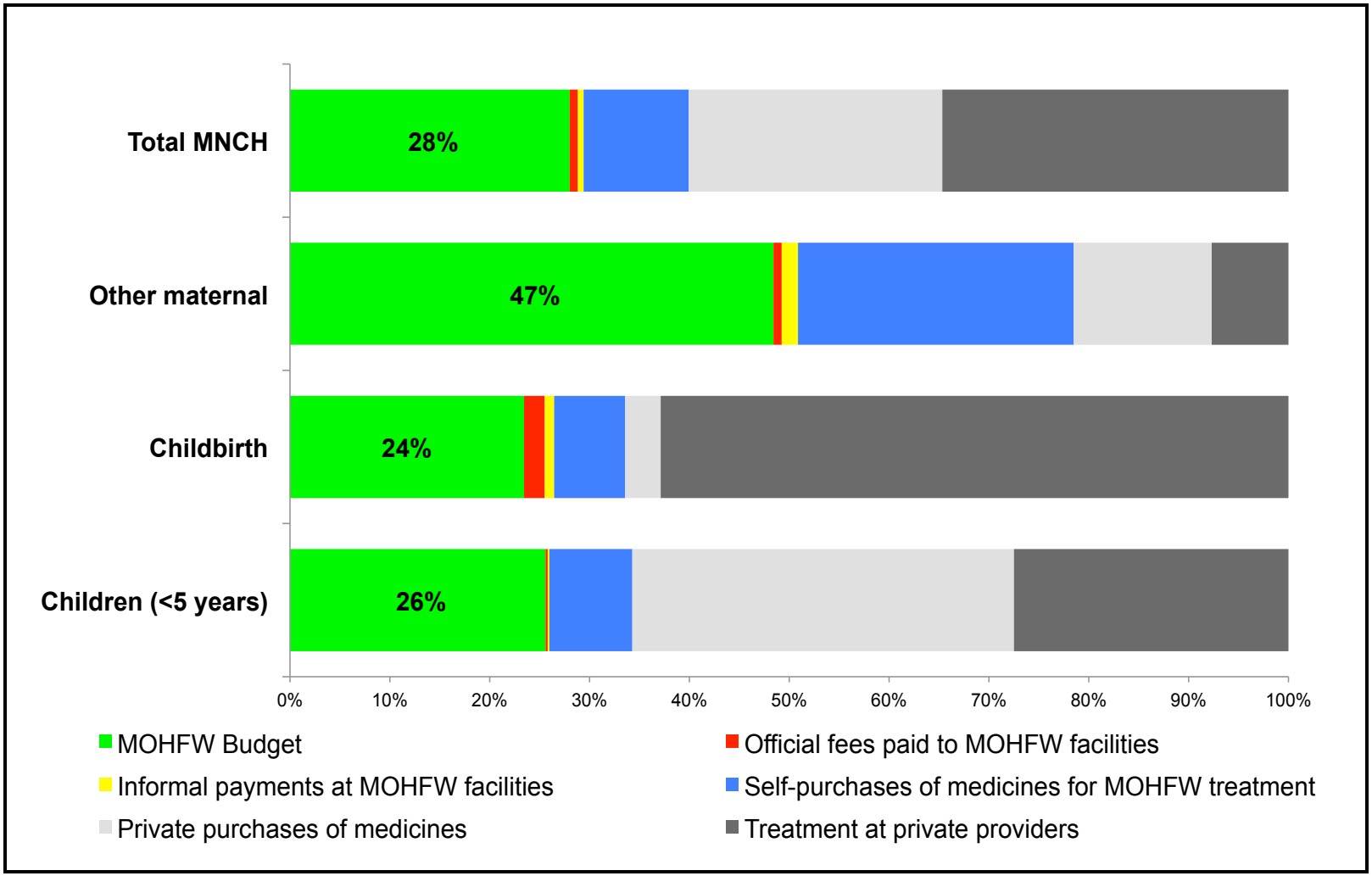

Figure 1: Sources of financing of MNCH care and its key components, Bangladesh 2006/07

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Bangladesh Policy Implications

- Public financing covers less than one third of MNCH costs
  - 26% of child treatment costs, 24% of childbirth costs
- Gross underfunding by government of childbirth provision, where needs are greatest
  - Greatest disparities in access. Greatest risk of impoverishment.
- Public provision fails to reduce costs of MNCH access by poor owing to inadequate funding of medicines

- **Increased government expenditures on MNCH should be prioritized to:**
  - **Expanding provision of facility-based child-birth and midwives**
  - **Increasing availability of medicines in MOHFW facilities**

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There is no quick or easy answer to track RMNCH flows in the highest priority countries

- It is critical for optimizing RMNCH and overall resource allocation in countries
- It is technically feasible to do annual monitoring in a large number of Asia-Pacific priority countries with basic NHA systems, but needs modest, sustained investments in national technical capacity
- Resources exist, but in practice not going to long-term capacity building at country level
- Approach will work for some, but not all

No easy answers – progress is possible, but will need changing the way business is done particularly in support of expenditure tracking

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Thank You