Tracking Resource Flows for RMNCH in Asia-Pacific Countries

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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.
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
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
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
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
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
Findings II
Validation of methods

Childbirth services

<table>
<thead>
<tr>
<th>Country</th>
<th>Admissions</th>
<th>Costs</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>11.5%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>6.0%</td>
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<tr>
<td>Korea</td>
<td>4.9%</td>
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</tr>
<tr>
<td>Australia</td>
<td>0.5%</td>
<td>2.4%</td>
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</table>

Child inpatient spending

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<td>6.3%</td>
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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)

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*Source: MOHFW Bangladesh NHA 2007*
## MNCH Spending - Govt. Facilities

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**Source:** MOHFW Bangladesh NHA 2007

### 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)
Bangladesh 2007
– MOHFW Facility Expenditure/Capita by Age and Condition (Taka)
# MNCH Spending – Hospital OOPE

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### 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

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*Source: MOHFW Bangladesh NHA 2007*
Bangladesh 2011

Average payments reported by mothers delivering at government facilities (Taka)
# MNCH Spending - Pharmacies

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Source: MOHFW Bangladesh NHA 2007

**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
Bangladesh 2007
– Pharmacy Expenditures Per Capita by Age and Condition (Taka)
Figure 1: Expenditure on MNCH care by major types of care, Bangladesh 2006/07

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%
Bangladesh 2007
– Who pays for what?

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