Resource tracking of Reproductive, Maternal, Newborn and Child Health

RMNCH

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THE TARGET
4. By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators:

1) total health expenditure by financing source, per capita; and

2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.
Financing is the mean, making the commitment feasible

Country level Commitments to implement the Global Strategy. An example: Ethiopia

Ethiopia will increase the number of midwives from 2050 to 8635; increase the proportion of births attended by a skilled professional from 18% to 60%; and provide emergency obstetric care to all women at all health centres and hospitals. Ethiopia will also increase the proportion of children immunized against measles to 90%, and provide access to prevention, care and support and treatment for HIV/AIDS for all those who need it, by 2015. As a result, the government expects a decrease in the maternal mortality ratio from 590 to 267, and under-five morality from 101 to 68 (per 100,000) by 2015.
Why monitor expenditure on health and RMNCH?

- Hold decision makers accountable to their commitments as expressed in their national health strategic plans and also on MDGs 4 and 5 (and/or other RMNCH goals).
  - Assess the level and distribution of resources regarding alignment with health sector priorities.
  - Evaluate sustainability of financing over time
  - Improve allocation of current spending, reduce waste of resources and improve efficiency.
THE APPROACH: HEALTH ACCOUNTS (HA)
Rational of the HA measurement

- To define what is to be measured, to identify the associated resource flows and the records documenting them

- Data compilation and classification, to collect, organize, summarize and present data in relevant indicators

- Basic accounting rules
  - To include all resources used during the accounting period, for resident population, avoiding double counting and omissions
  - All resources are included regardless the place of consumption and the origin of the financing (hospital, clinic, medical office, pharmacy, internet, domestic/external, etc.)
What is consumed has been produced and financed

- Health promotion and prevention
- Diagnosis, treatment, cure and rehabilitation of illness
- Caring for persons affected by chronic illness
- Caring for persons with health-related impairment and disability
- Palliative care
- Community health programmes
- Governance and administration of the health system.

**Financing**

- Revenue
- Schemes

**Production**

- Production factors
- Providers

**Consumption**

- Health Functions
- Beneficiaries
  - Geopolitical, SES, age and gender, ICD/BoD
  - Capital, trade, products
The HA strategy: HA, RHA, CHA & RMNCH

SHA 2011 framework
- Financing Dimension
- Provision Dimension
- Consumption Dimension

COIA indicators
- THE by source and per capita by source
- RMNCH by source and per capita by source

Revenues of financing schemes
- Government
- Corporations
- Etc.

Beneficiary characteristics
Spending by:
- Age and gender
- Disease groups
- Geographical
- Socioeconomic status

Selected items for RMNCH
Spending by:
- Age and gender (0-5 years)
- Disease groups (FP & maternal)

Specific field analysed
Reproductive health (RHA)
Child health (CHA)

Selected items for RMNCH
Spending by:
- CHA: Child health
- RHA Disease groups (FP & maternal)
The Scope

- Expenditure on reproductive health includes:
  - Antenatal, delivery, post-partum
  - High-quality services for family planning, including infertility services
  - Eliminating unsafe abortion.
  - Combating STIs including HIV, reproductive tract infections, and morbidities.
  - Promoting sexual health.

- Expenditure on child health during a specified period:
  - Goods & services & activities delivered to the child after birth or its caretaker, whose primary purpose is to restore, improve and maintain the health of children between zero and less than five years of age.
Selected key indicators

THE by source & per capita RMNCH by source & per capita

Government: THE & per capita RMNCH & per capita

- Child health (under 5)
  - THE CH, CHE, per capita, share to GDP

- CH interventions (e.g.)
  - Expenditure on breastfeeding
  - integrated management of sick children
  - on ITNs
  - on immunizations

- Reproductive health
  - TRHE, CHE, per woman, share to GDP

- RH interventions (e.g.)
  - Maternal health
  - Family planning
  - Abortion
  - Adolescent sexual health
  - Cancers, RTIs, STI and other morbidities
RMNCH Reporting levels

Main financing sources for health and RMNCH:
- Government, external resources, and private (household)

Reporting based on maturity of health expenditure data:
- Starting point is the government expenditure (e.g. GET) + external resources outside of government
- When health accounts exist, a proportion of OOPS can be estimated
- When full distribution or RHA and CHA exists, RMNCH data can be generated, considering preferably:
  • Triangulation and validation not to overstate spending,
  • Generating data within a HA process
  • Including at least two main classes: RMNCH & non RMNCH components to get a full oversight of resources used (RMNCH + non RMNCH = HA Totals)

Government expenditure is a beginning, but not enough to assess any financing strategy
SOME EXAMPLES OF RESULTS
HA Partial Distributional Table: Shows allocation to one relative to others

Source: General NHA, HIV and AIDS, TB, Malaria, RH and CH Tables 2008

SOURCE: Tanzania National Health Accounts (NHA) Year 2002/3 and 2005/6, page 40
Health expenditure by condition
Sri Lanka 2005

Expenditure per capita (Rupees)

- Maternal conditions
- Benign neoplasms
- Endocrine and metabolic
- Congenital anomalies
- Blood/Immune Disorders
- Oral health
- Neonatal causes
- Mental disorders
- Nutritional deficiencies
- Diabetes mellitus
- Malignant neoplasms
- Musculoskeletal
- Genitourinary
- Nervous system disorders
- Skin diseases
- Digestive system
- Cardiovascular
- Respiratory infections
- Chronic respiratory disease
- Injuries
- Infectious and parasitic

Investigation of signs, symptoms and other contact

Female
Male
Health expenditures per capita by age and sex, Sri Lanka 2005

Expenditure per capita by age & sex (R upees)

- Male
- Female
- Female excluding (maternal conditions)

Age (years)

Health expenditures per capita by age and sex, Sri Lanka 2005

IHP
Sri Lanka

World Health Organization

Tracking RMNCH expenditures

16
Subaccount: More in-depth view using several ICHA classifications

2002
- Public, 8%
- Households, 11%
- Other private, 2%
- Donor, 80%

2006
- Public, 14%
- Households, 13%
- Other private, 1%
- Donor, 71%

THERH: RWF 6,982,368,741  
(US$ 12,655,180)

THERH: RWF 10,561,325,959  
(US$ 19,141,922)
Findings from RH accounts compared across countries:

Expenditure per woman of reproductive age (US$ PPP-adjusted) in relation to MMR


Data on Maternal Mortality Ratio in 2005 per 100,000 live births from World Health Statistics 2008.
HOW TO SUPPORT HA DATA USE
Plan of action of HA (& specific RMNCH accounts)

1. Ensure demand and commitment: RMNCH partners informed, HA demand help to address problems and constraints

2. Finding a stable "home" for HA: HA & RMNCH involvement, $

3. Drafting a work plan and assess its costs: use SHA & the guides for CH and RH accounts.

4. Setting up a technical team & a steering committee: HA, RMNCH, statistical experts, providers & users of RMNCH data

5. Assessing information availability & needs: e.g. census of data sources: expenditure, utilization, costs. Piggyback on other surveys.

6. Institutionalization, a full cycle:
   - HA planning and budgeting processes, demand for data by country leaders,
   - production and dissemination of HA data, the use and application of HA in policy decisions
### NATIONAL HEALTH ACCOUNTS (NHA) FRAMEWORK AND GOVERNANCE

There is an officially approved NHA framework built upon international guidelines.

There is a formal governance mechanism that specifies coordination, management, national indicators and budget for implementing the NHA.

### COMPACT

There is a formal agreement (or compact) between government and partners that requires reporting on partner commitments and disbursements, and donor funded expenditures on health, (including on RMNCH).

### COORDINATION

There is an NHA steering committee that provides technical oversight on data needs, methods of production and data use.

Key stakeholders are actively involved in the production of NHA (including government stakeholders at national and subnational level, CSOs, NGOs, partners, health insurance companies).

### PRODUCTION

There is adequate human capacity at national and subnational levels to produce NHA data and core indicators.

Government expenditure data conversion into NHA format is automated.

There is a central database for automated production of standard NHA tables, and methods and sources are well documented and accessible.

### ANALYSIS

Analytical summaries are produced annually including time series, policy and equity analyses.

NHA indicators and analyses are publicly accessible.

### DATA USE

NHA data including RMNCH data are an essential element of annual reviews and are used in the development of national policies, including RMNCH-specific policies.
Accounting guidelines
WHO NHA: http://www.who.int/nha/

CHA: http://www.who.int/nha/developments/guide_ch_sub.pdf
RHA: www.who.int/nha/.../guide_to_producing_rh_subaccounts_final.pdf


http://dx.doi.org/10.1787/health_glance-2009-72-en

Thank you