

Monitoring Resource Flows for Reproductive, Maternal, Newborn, Child and Adolescent Health and Universal Health Coverage

Progress towards RMNCAH and universal health coverage (UHC) will require both more money for health and more health for money to achieve affordable access for all to quality health care services. The Lancet Commission on Investing in Health estimated that an average incremental cost of \$64 billion per year in 2016-2025 and \$83 billion per year in 2026-2035 is needed to achieve a grand convergence in health in low and middle-income countries. The Global Financing Facility (GFF) estimated that the resource gap for reproductive, maternal, newborn, child and adolescent health (RMNCAH) alone is \$33.3 billion in 2015 and \$16.5 billion in 2030. As the economies of these countries grow, most of the resources to fill these gaps are likely to come from government spending. Complementary efforts will however be necessary to increase levels of private sector investment and ensure that development assistance for health (DAH) effectively complements domestic spending. At the same time, increases in spending need to be accompanied by efficiency enhancing measures to get better value for money.

More reliable and complete information on resource flows and how they link to desired health outcomes are needed to inform local policy processes and monitor progress in financing RMNCAH and UHC. The growing momentum surrounding monitoring for UHC has tended to focus on coverage of health care services and catastrophic and impoverishing expenditures. However, access to health care and financial protection depend on the resources available to the health sector and the policies and institutions that govern the use of funds. National Health Accounts (NHA) is the widely accepted process through which countries monitor the flow of money in their health sector. Yet the quality and detail of data are often insufficient, methodological issues prevail, and in many countries, comprehensive NHA are yet to be produced regularly.

National Health Accounts often lack the quality and disaggregation of data to allow for a comprehensive and accurate assessment of financing patterns of RMNCAH and UHC. While the quality of data on public resource flows tends to be in general of better quality, countries face challenges in accounting for private sector resource flows. For example, public-private partnerships are not always on-budget. To capture all private capital investment, it would require financial documentation from private companies and data from registration and licensing systems. Similarly, a large share of DAH tends to be off-budget and efforts are needed to account for these resource flows, not only to capture the full picture of external financing, but also to estimate the effects of DAH on domestic financing. In addition to improvements in quality, further disaggregation of data is necessary to link expenditures with specific health outcomes such as RMNCAH. Measuring disease and age-specific expenditures within NHAs is possible, but adds further complexities to the NHA exercise. Facility surveys or administrative claims data by level of provider are needed to assess the distribution of expenditures by services related to specific age and disease categories. This may require time and motion studies to estimate the labor cost required to perform related activities. Similarly, individual level data on utilization is needed to assess out-of-pocket (OOP) expenditures by age and disease categories. In countries where OOP financing is predominant, considerable effort is needed to assess expenditures patterns and, yet, there is no standardized approach.

In parallel to data issues, the use of National Health Accounts is hampered by methodological challenges. In the first instance, there remain issues of expenditure classification, for example, the allocation of expenditures to diseases is complicated by patients presenting with co-morbidities (e.g., an HIV positive pregnant woman). More significant challenges pertain to the use of NHA information for policy making. For example, some research suggests that DAH may significantly crowd out domestic financing of health; however, there is no widely agreed methodological approach to assess and quantify such substitution effects. Similarly, the 2010 World Health report estimated that 20-40% of all resources spent on health are wasted; yet, there is no established framework to quantify efficiency and measure it systematically.

Finally, in many low and middle income countries, NHA have yet to be institutionalized. Over the years, governments and development partners have invested in establishing NHA in many countries, however, with mixed results. NHA have been successfully institutionalized where they are carried out by national organizations in response to demands for relevant information by policy-makers. Yet, in many countries, NHA have been a one-off effort, in which externally financed, donor-driven NHA “projects” typically failed to build adequate local technical and institutional capacity. In these countries, local capacity has often been insufficient to analyze and make further use of the information generated by NHAs. And even when countries manage to institutionalize NHA, the frequency of detailed exercises remains a matter of debate. For example, the complexity and costs of producing disease and age specific NHA means that only a dozen OECD countries track these patterns routinely.

Despite these challenges, the need for more systematic approaches to tracking health resources is widely recognized to better link resource flows to needs and outcomes. Some low- and middle income countries, such as Bangladesh, Fiji, Sri Lanka and Thailand, have led the way using the original OECD methodology to produce estimates by age and disease. Many bilateral and multilateral organizations continue to provide support to countries under the overall coordination of the World Health Organization (WHO). Under WHO guidance, over 30 countries have finished one NHA with estimates by age and disease. WHO will also produce a general guidance note for implementers by September 2015.

The GFF provides an important opportunity to support countries in producing better resource flow data for RMNCAH and UHC policy-making. First and foremost, support for the design and implementation of country health financing strategies could help countries institutionalize NHA, including, as needed, age and disease estimates and the use of these data for RMNCAH and UHC policy-making. In addition, the GFF could foster consensus about methods to analyze and indicators to monitor financing system outcomes relevant for RMNCAH and UHC. In parallel to discussions with GFF countries, consultations with development partners have begun on how to seize these opportunities without duplication of efforts; as of now, primarily with partners that have traditionally supported the institutionalization of NHA, including some represented in the Investor Group. For the coming months, the goal is to broaden the discussion and facilitate the development of a joint work program. Further details on this will be discussed with the Investors Group at the September 28th meeting.