Bangladesh National Health Accounts

A look back and thoughts on the future

Dr Ravi P. Rannan-Eliya

Dissemination of Bangladesh National Health Accounts (BNHA 1997–2012)

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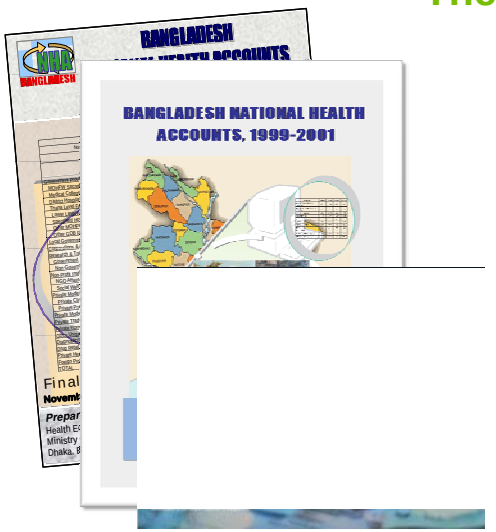
IHP
INSTITUTE FOR HEALTH POLICY

Then and now



- Achievements and progress
- The numbers
- Thoughts for the future

International Standards

- Bangladesh – Early adopter and upgrader to international standards
  - BNHA-I: *SHA Beta*
  - BNHA-II – III: SHA 1.0
  - BNHA-IV: SHA 2011
- Dual reporting
  - Capability to report to both national and international frameworks
  - Still not universal in most countries

Methods – Public expenditure

- Progress
  - BNHA-I
    - Manual analysis of government paper reports
  - BNHA-III, IV
    - Automated analysis of electronic CGA data
- Where is Bangladesh?
  - Use of electronic audit/treasury data still only done in a few countries: Fiji, Indonesia, Malaysia, Sri Lanka
  - Similar to WB BOOST Initiative
- Future steps?
  - May depend on improvements in CGA
  - Giving access to BNHA processed data

Methods – Private expenditure

- Advances
  - Pre-BNHA
    - Estimates usually based on often biased household survey data
  - BNHA-I
    - Household survey data + IMS industry data
  - BNHA-IV
    - Full adoption of international best practices
    - Full integration of multiple data sources – household surveys, IMS, provider surveys, etc.
- Where is Bangladesh?
  - Already best practice
  - Still room for improvements in quality of methods

Methods – Reliability and continuity

- Progress made
  - BNHA-I – BNHA-III
    - Separate estimations, not always comparable
    - Poor record keeping between projects
  - BNHA-IV
    - Full revision of all estimates since 1998 in consistent manner
    - Better record keeping?
- Future agenda
  - Moving towards incremental improvement of methods and updating of components
  - Reducing costs of data collection whilst improving quality

Institutionalization

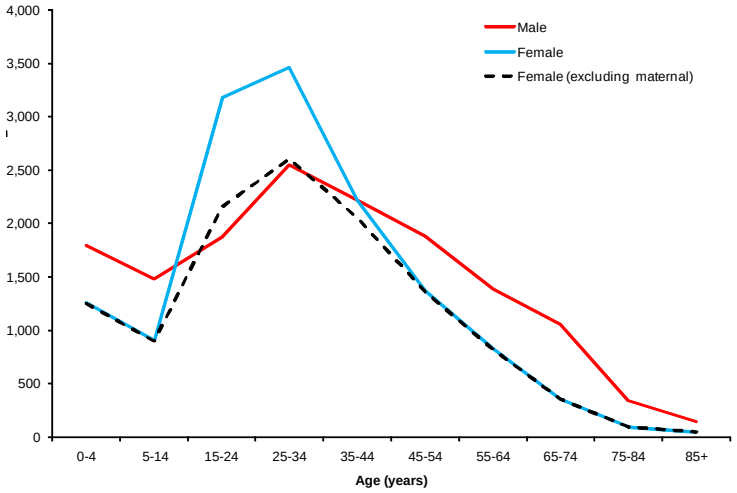
- Progress
  - Shift in ownership and leadership from development partners to MOHFW
  - Shift from projectized estimates to more continuous activity
  - Development of partnerships between MOHFW, other government agencies, technical experts
  - Decreasing need for international TA
- Future agenda
  - Every country has to find its own solution
  - How to build on what worked and what hasn't worked
  - Shifting from short-term to long-term procurement
  - Increasing access and use of BNHA data

Uses

- Progress made
  - Increasing use of BNHA for policy analysis, e.g., PERs, BIA
  - Demonstrated potential for resource tracking: HIV/AIDS, RMNCH, but multiple, uncoordinated efforts still occur

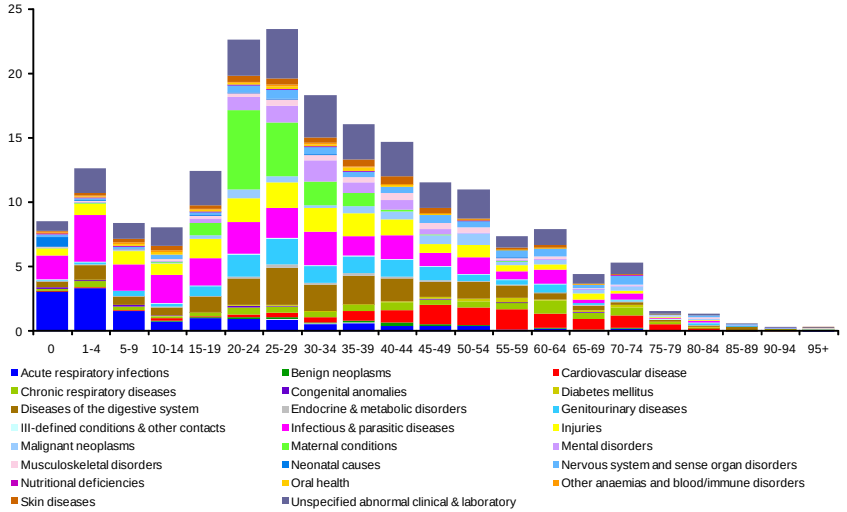
BNHA Extensions –

MOHFW Facility Expenditures by Age and Sex (Tk million)



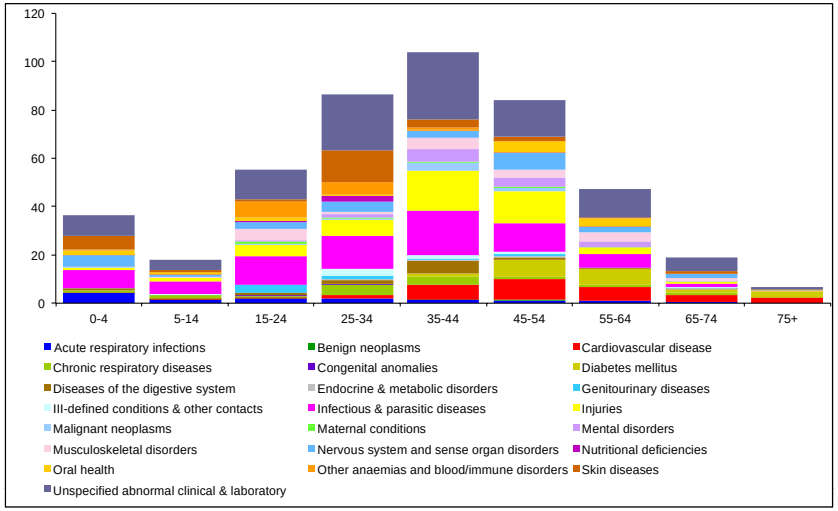
BNHA Extensions –

MOHFW Facility Expenditure Per Capita by Age and Condition (Tk)



BNHA Extensions –

Pharmacy Expenditures Per Capita by Age and Condition (Taka)



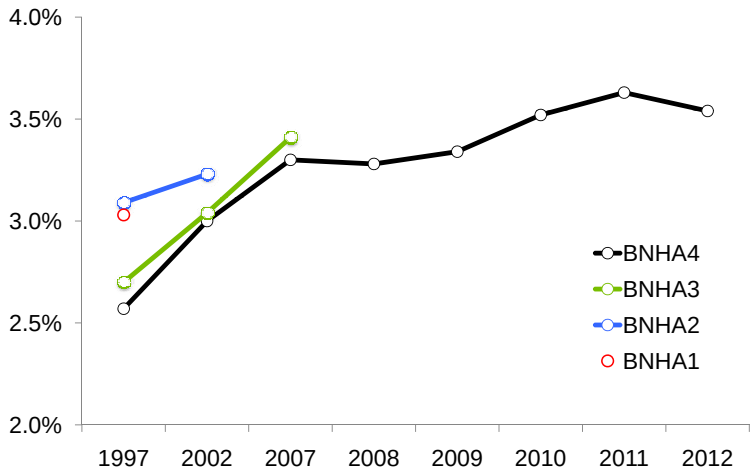
Uses

- Progress made
  - Increasing use of BNHA for policy analysis, e.g., PERs, BIA
  - Demonstrated potential for resource tracking: HIV/AIDS, RMNCH, but multiple, uncoordinated efforts still occur
- Future agenda
  - Single focal point for official resource tracking with efforts integrated or linked to BNHA
    - Disease accounts and GFATM as starting point
  - How can BNHA be made available for others to use?

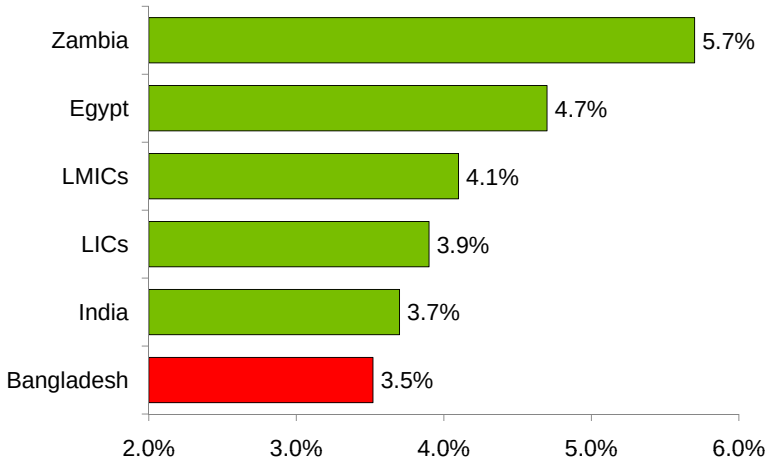
The Numbers – What have we learnt?

- Bangladesh was a very low spender, and still is
- Despite the rhetoric, government expenditure has fallen continuously
- Donor financing has not led to increased public expenditure, despite growing economy
- Government spending on hospital care was low and remains low
- Shift away from NGOs in spending

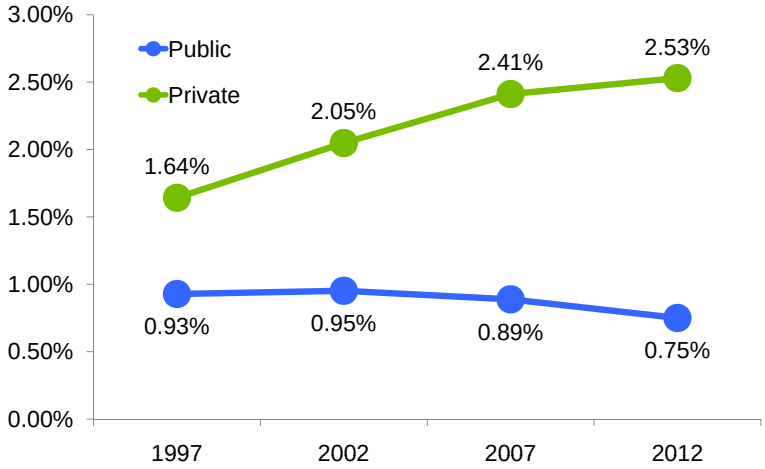
Changes in TEH (% GDP) with successive BNHA rounds



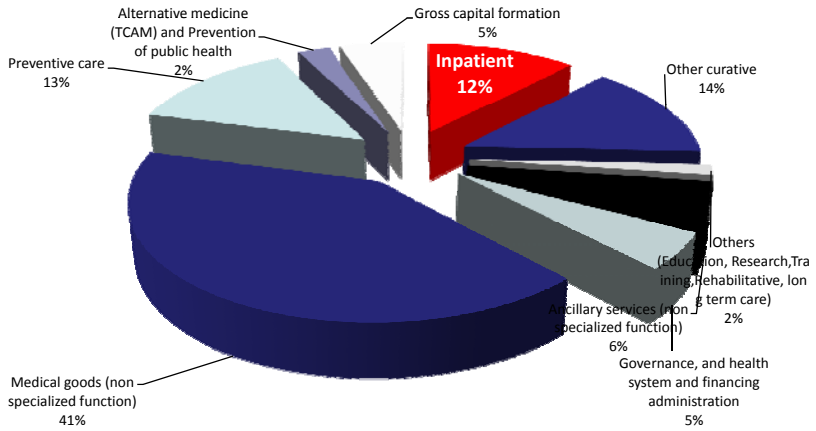
Bangladesh remains a low spender on health, 2010 (% GDP)



Public and private expenditures 1997–2012 (% GDP)



THE by BNHA Functional Classification 2012



- **Inpatient care only 12% of total expenditures (up from 10%) compared to 20–40% in other countries**

The Numbers – What have we learnt?

What does this mean for UHC?