



***Reducing financial barriers to
obstetric care in low income
countries***

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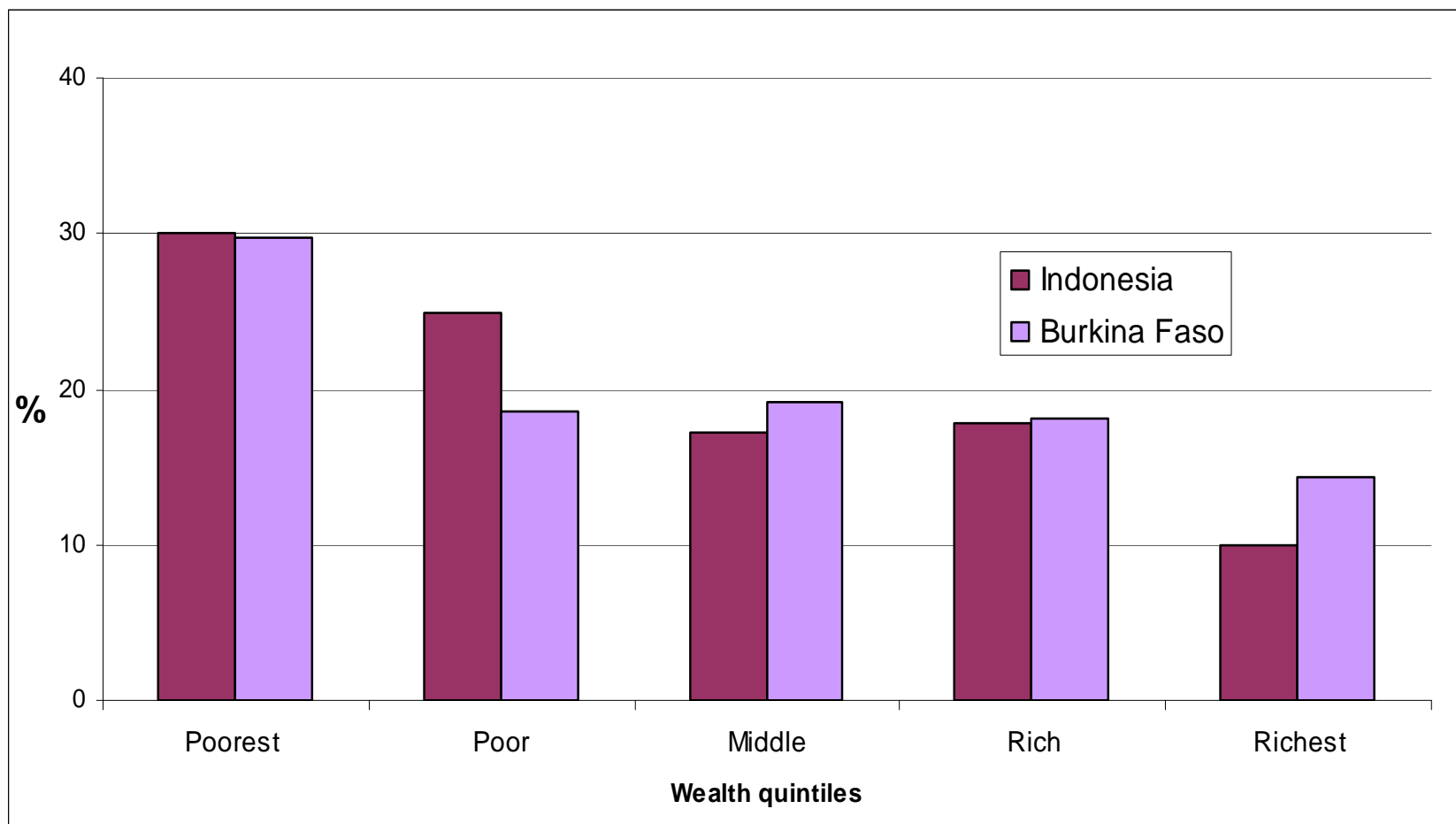
- 1. The role of financial barriers for delivery care in low-income settings**
- 2. Approaches to addressing financial barriers**
- 3. Some recent case studies: experiences of different approaches**
- 4. Policy recommendations on effective strategies**

Problem statement:

Why do financial barriers matter?

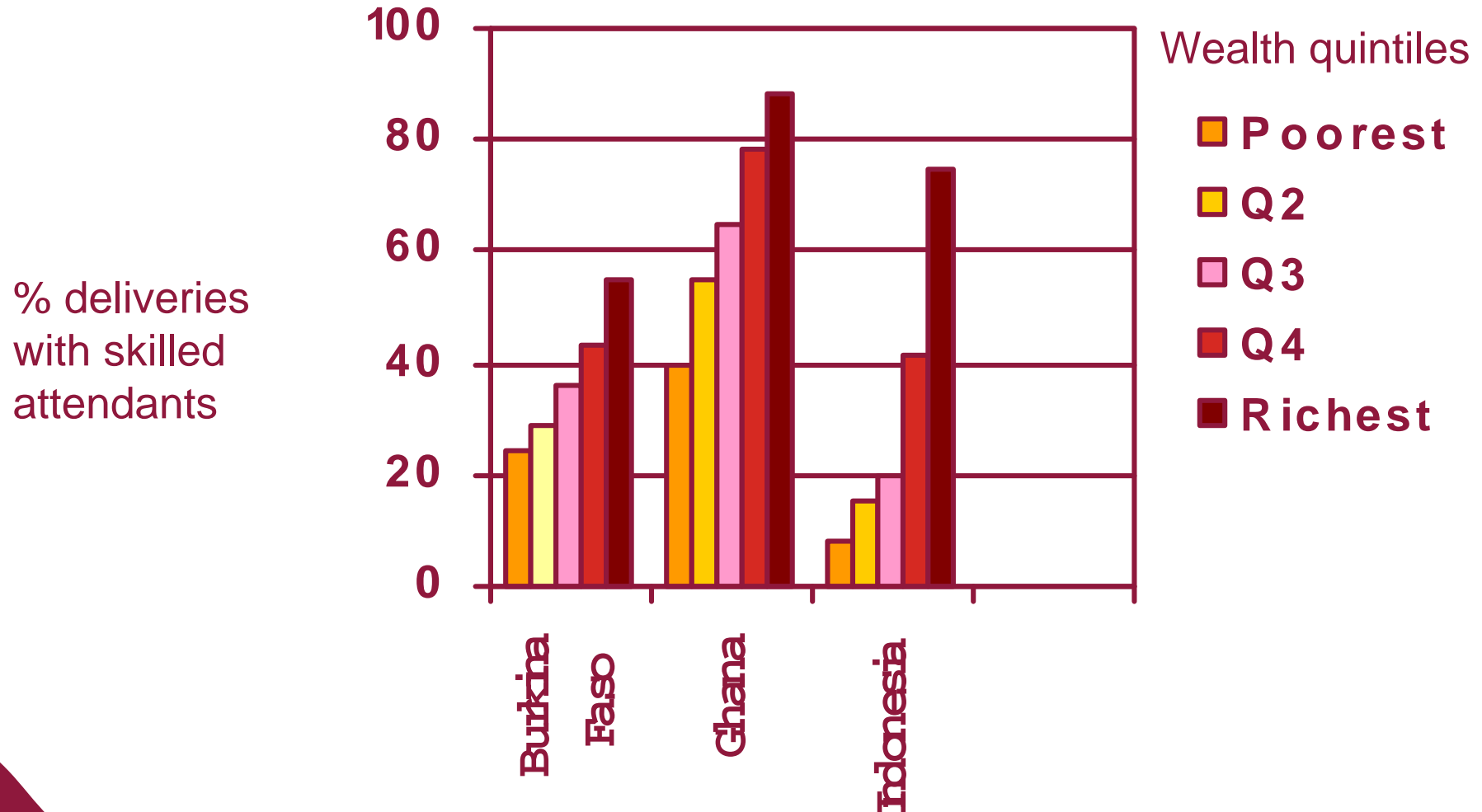
1. Burden of mortality is clustered in the poor

% distribution of maternal deaths by wealth quintiles at sub-national levels: Indonesia & Burkina Faso

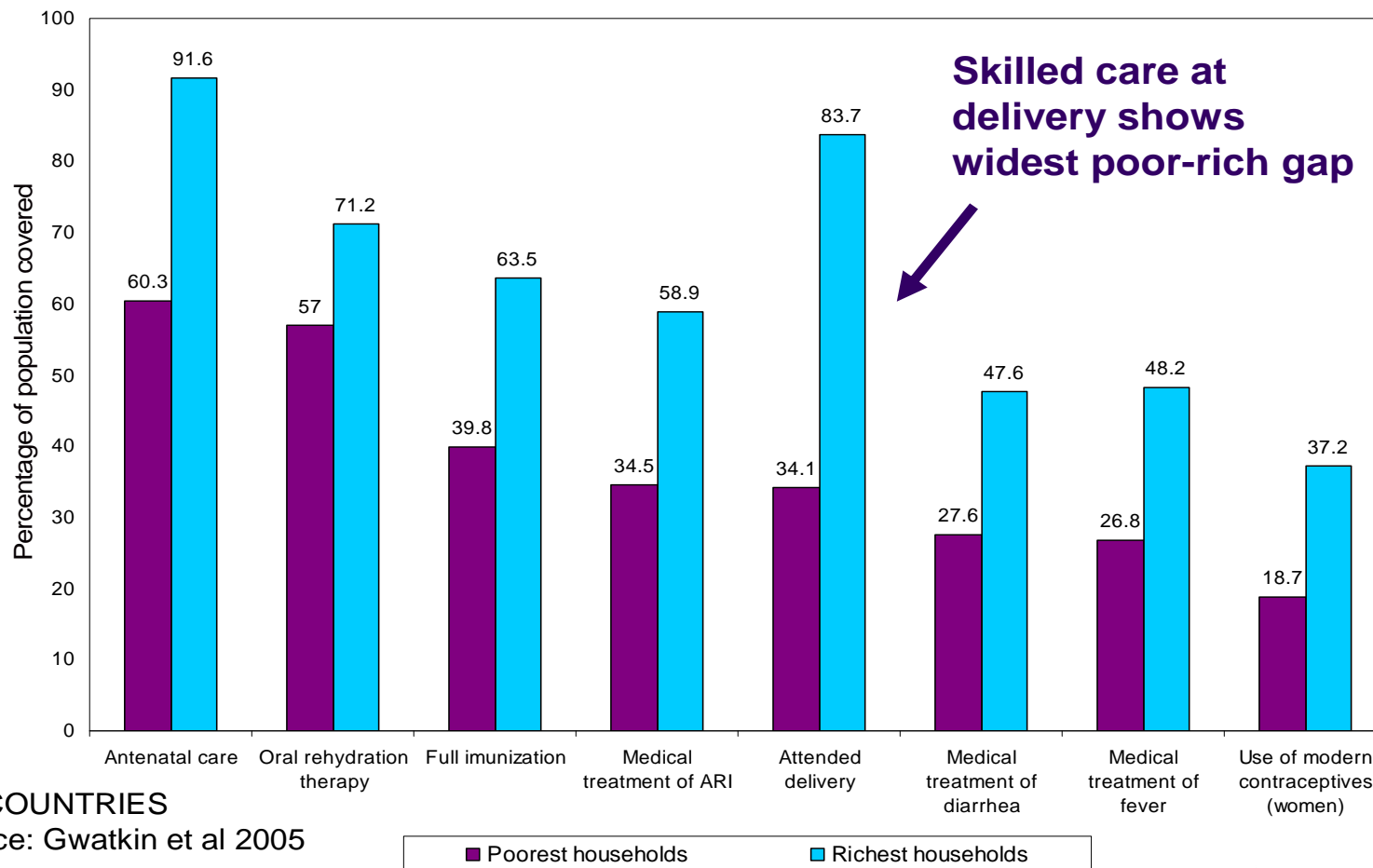


2. Access to skilled care also linked to wealth

Coverage of skilled care at delivery from Impact sub-national data

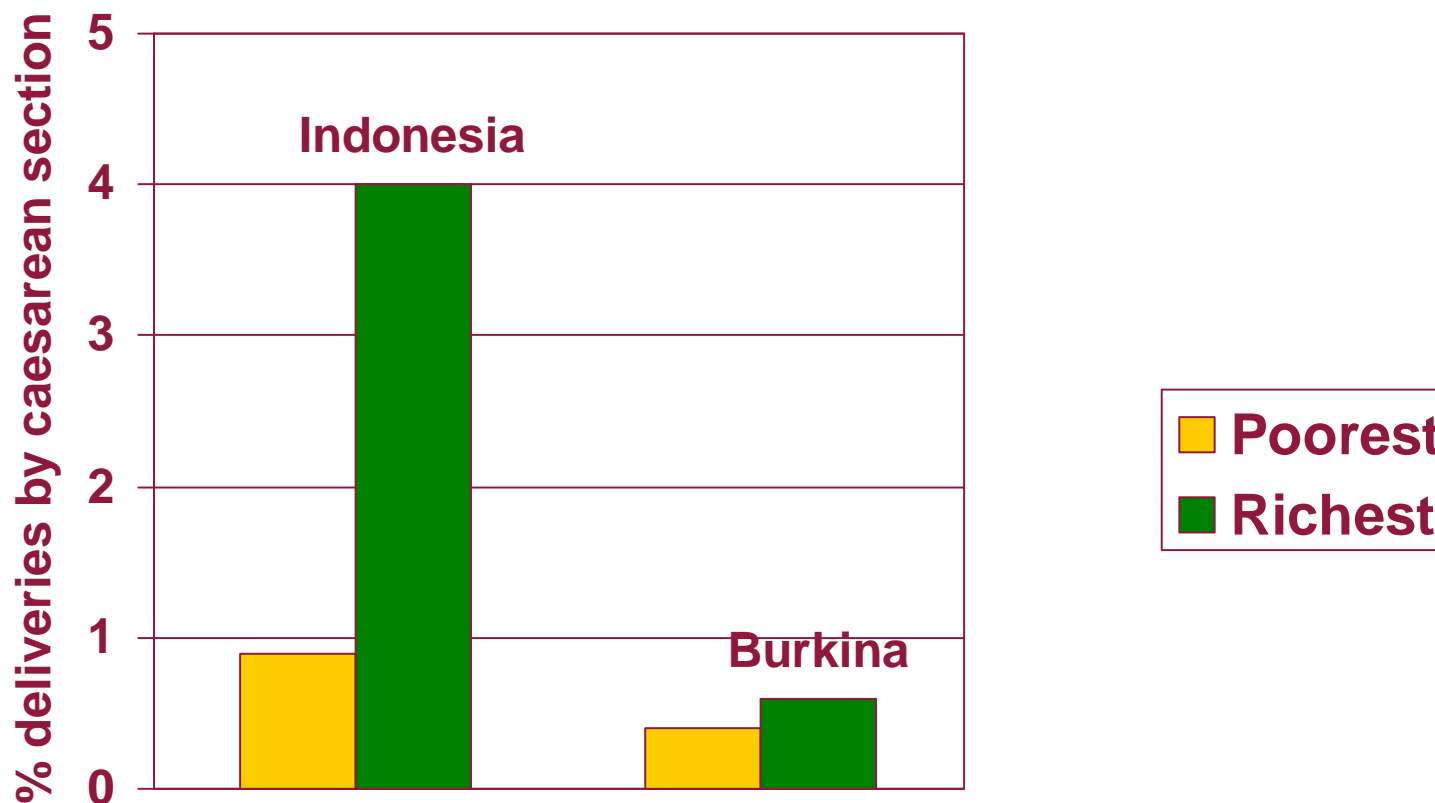


Coverage of care varies between poor and rich households*



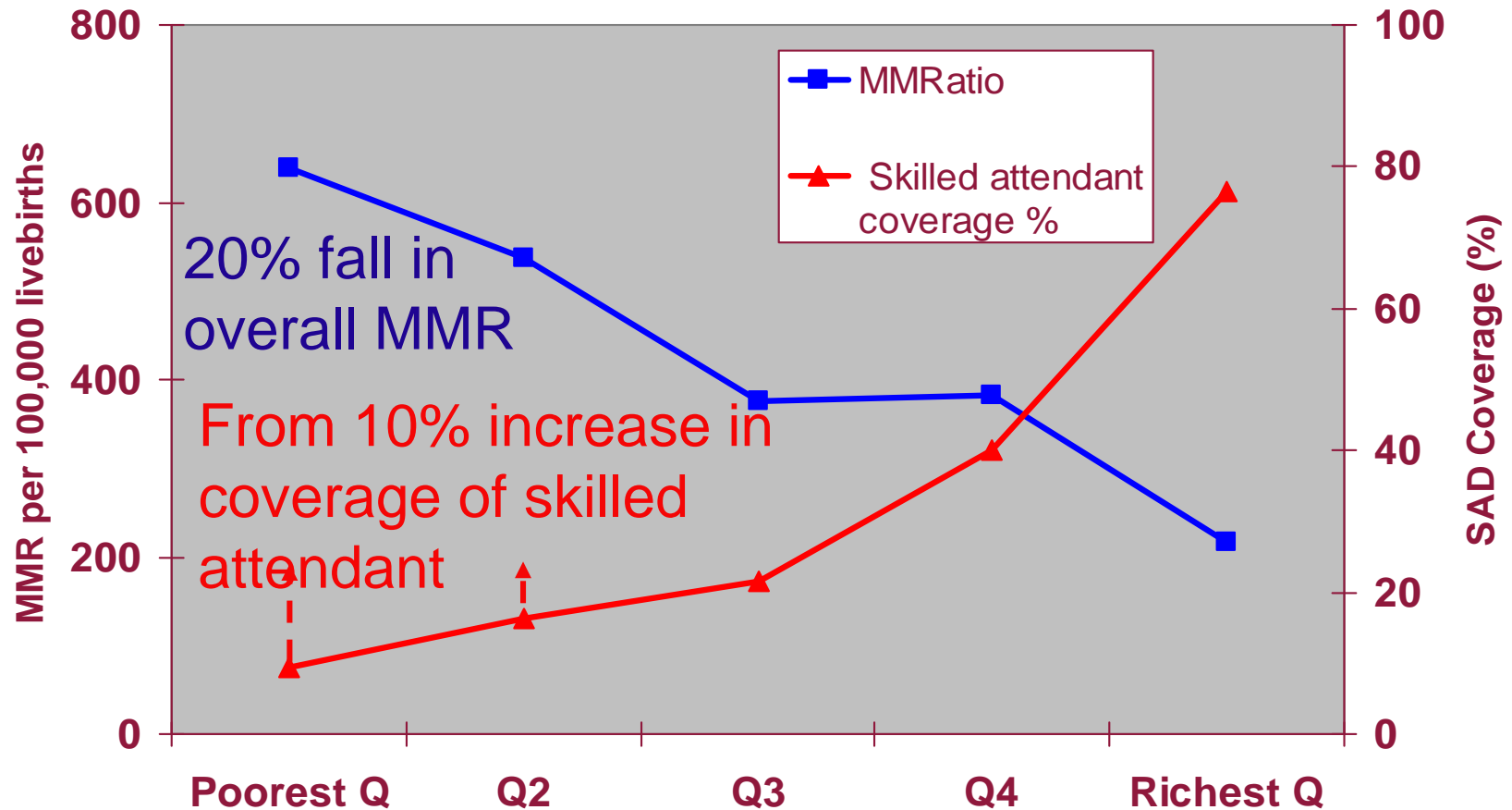
3. Emergency care is often not available to the poor (or even the non-poor)

Indonesia & Burkina Faso: Poor-rich gap in caesarean sections (sub-national, Impact data)



4. Implications for reducing maternal mortality

Almost a third of overall maternal mortality is from poorest quintile



Modelled using data from Immpact studies, Indonesia 2006.

5. Low ability to pay (especially for EmOC, for all households)

Average cost of care to mothers in US\$

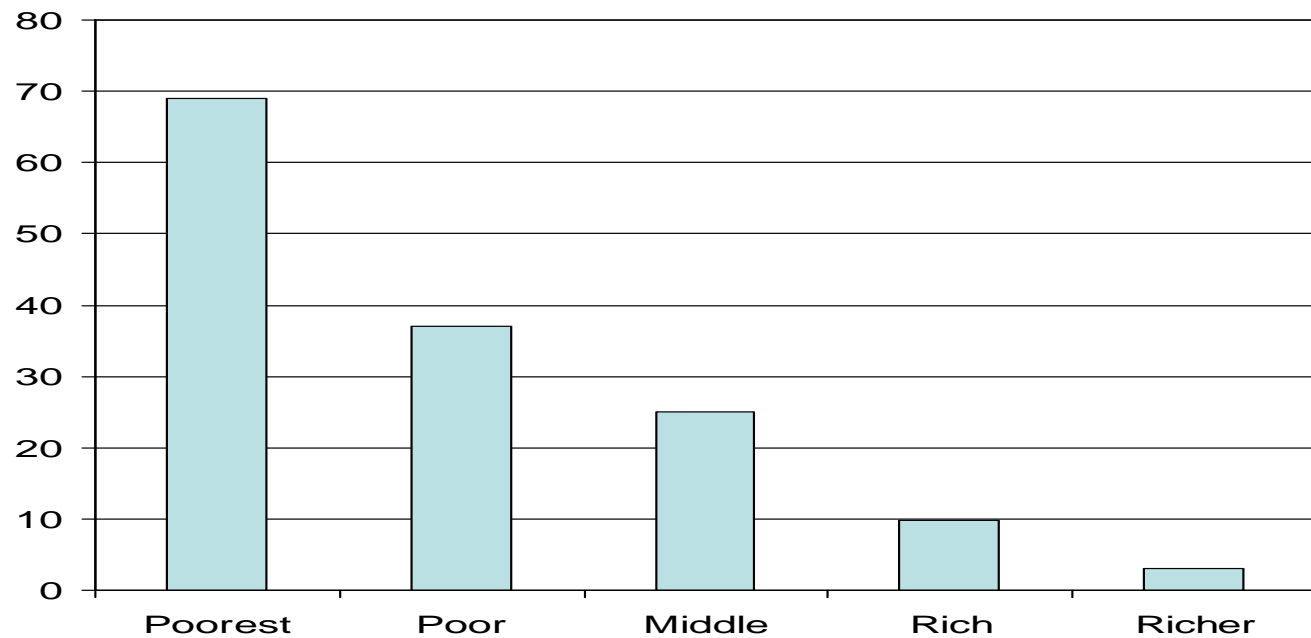
	Normal delivery	Caesarean section
Indonesia	99	425
Ghana	43	229
Burkina Faso*	39	124

* Cost represents 43% & 138% respectively of annual per capita income in poorest households

Catastrophic payments are much more common for poor

Indonesia sub national: % distribution of catastrophic payments* for care in obstetric complications by wealth quintiles

*40% or more of a household's disposable income



6. Payments for health care can have lasting adverse consequences

Impact findings in Burkina Faso:

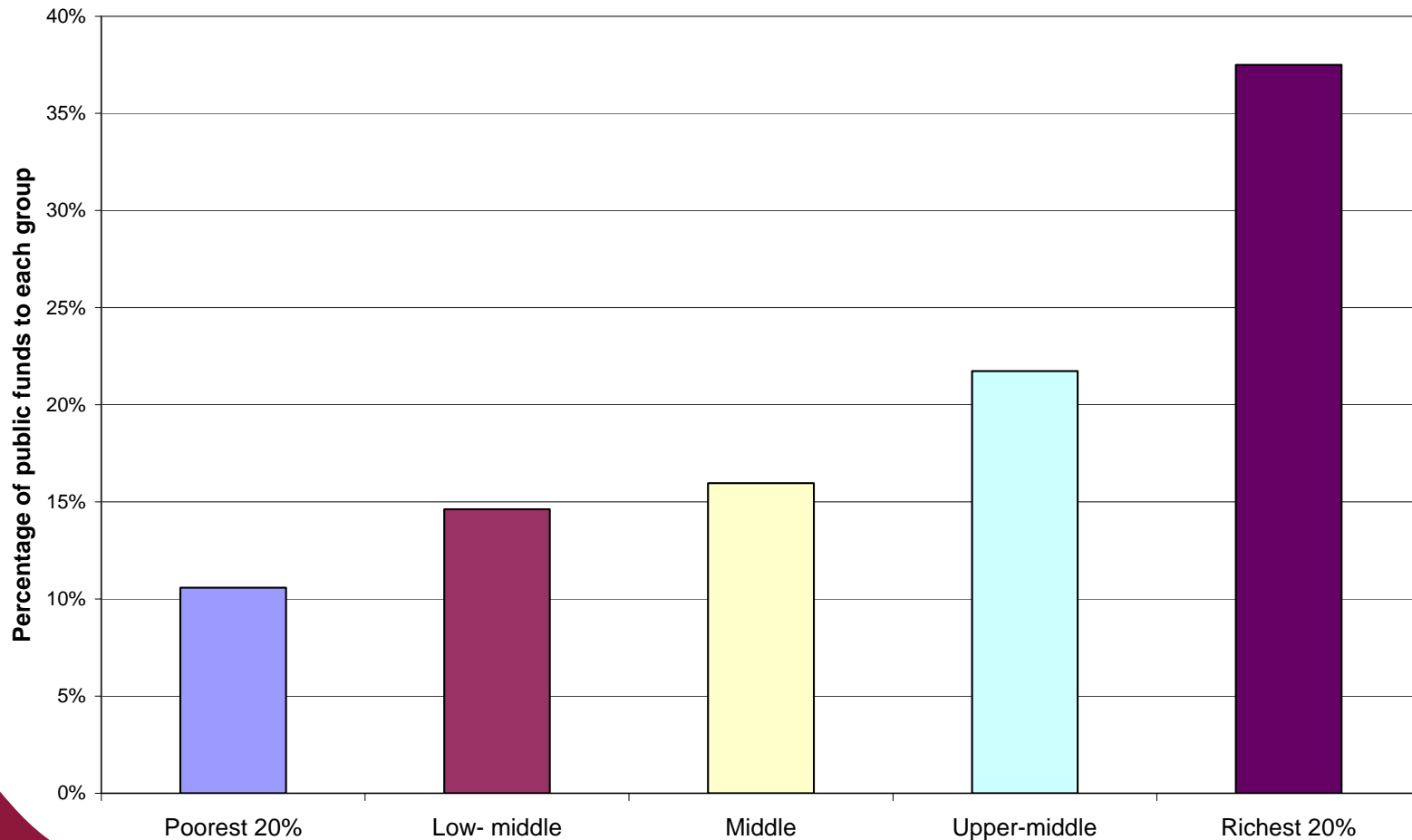
- Poorest women had highest level of asset sales
- Poorest women spent least on care in absolute terms, but largest proportion of household income
- All women with near-miss complications reported spending of savings, borrowing, & sale of assets
- 8% of women with normal deliveries reported borrowing to meet the cost of care
- Also high and longer term social, mental and physical consequences of near-miss events



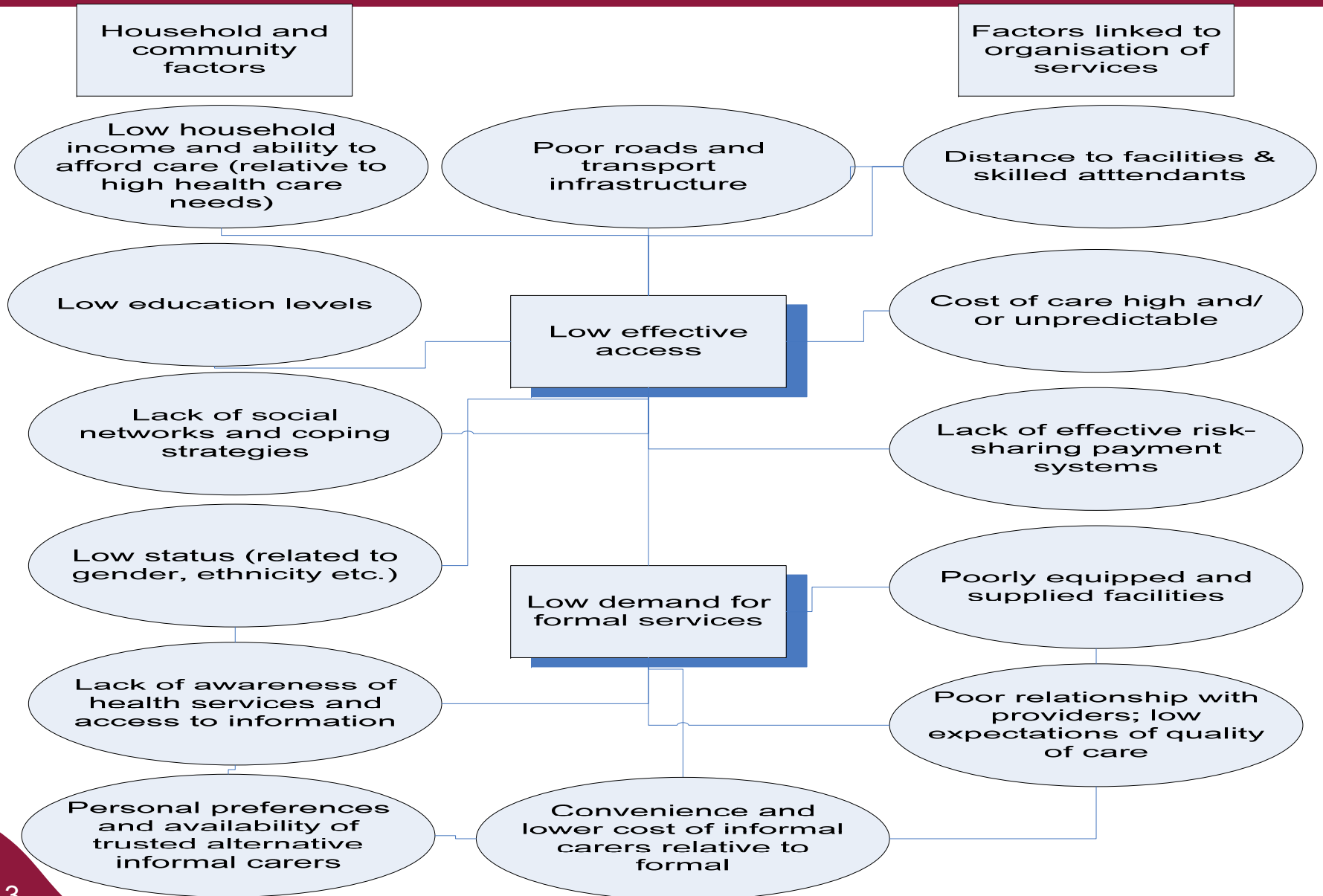
For more details see:
Storeng, K.T.; Baggaley, R.F.; Ganaba, R.; Ouattara, F.; Akoum, M.S.;Filippi, V.; (2008) **Paying the price:** The cost and consequences of emergency obstetric care in Burkina Faso. *Social Science and Medicine*, 66 (3), 545-557.

7. Public health spending often favours the rich (who can overcome barriers to access)

Indonesia: the poor continue to benefit far less from public maternal health spending than the rich



Barriers on demand side multiple and complex, but often interconnected with poverty



Reducing financial barriers to obstetric care in low-income countries

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Supply-side:

- Fee exemption or reduction
- Waivers
- Tackling informal payments
- Making fees flat rate & predictable

Demand-side:

- Cash transfers
- Vouchers
- Loans
- Prepayment/ community health insurance
- Subsidised access to social health insurance

Indirect approach:

- All reforms which affect service quality, availability, acceptability, convenience etc.

Examples from book:

- Ghana, Senegal and Burkina
- Health equity funds, Cambodia
- Mauritania EmOC insurance

- India
- Cambodia vouchers

- Guinea, Mauritania
- Bolivia

5. Lessons from recent experiences of policies addressing financial barriers

National delivery exemptions policies:

- Ghana delivery exemptions 2004-5
- Senegal delivery exemptions. 2005-6
- Burundi: free MCH 2006
- Burkina Faso: 80% subsidy all deliveries, 2006
- Malawi: free maternal health via CHAM in selected areas
- Mali: free caesareans in recent years
- Sudan: free care for under-5s and caesareans, 2008
- Other smaller scale schemes, often via NGOs (e.g. two districts in Niger)

Few fully evaluated and published yet but growing interest



Impact findings on fee exemption policies

Ghana – universal free deliveries in public and private facilities from 2004

- Impact evaluation found significant increases in utilisation but shortfalls in national funding and concerns about quality of care (before and after). Biggest increase in utilisation for poor but household out-of-pocket cost reductions greater for better off households. Problems of sustainability with focus on developing NHIS. (Exemptions now provided through NHIS, since 2008.)

Senegal free normal deliveries (at HP and CS level) and free caesareans (at CSII and HR level) since 2005

- Impact evaluation found increased utilisation but, again, household costs remained high and problems with reimbursing lower facilities and kit supply. Geographic exclusion for those living far from facilities.

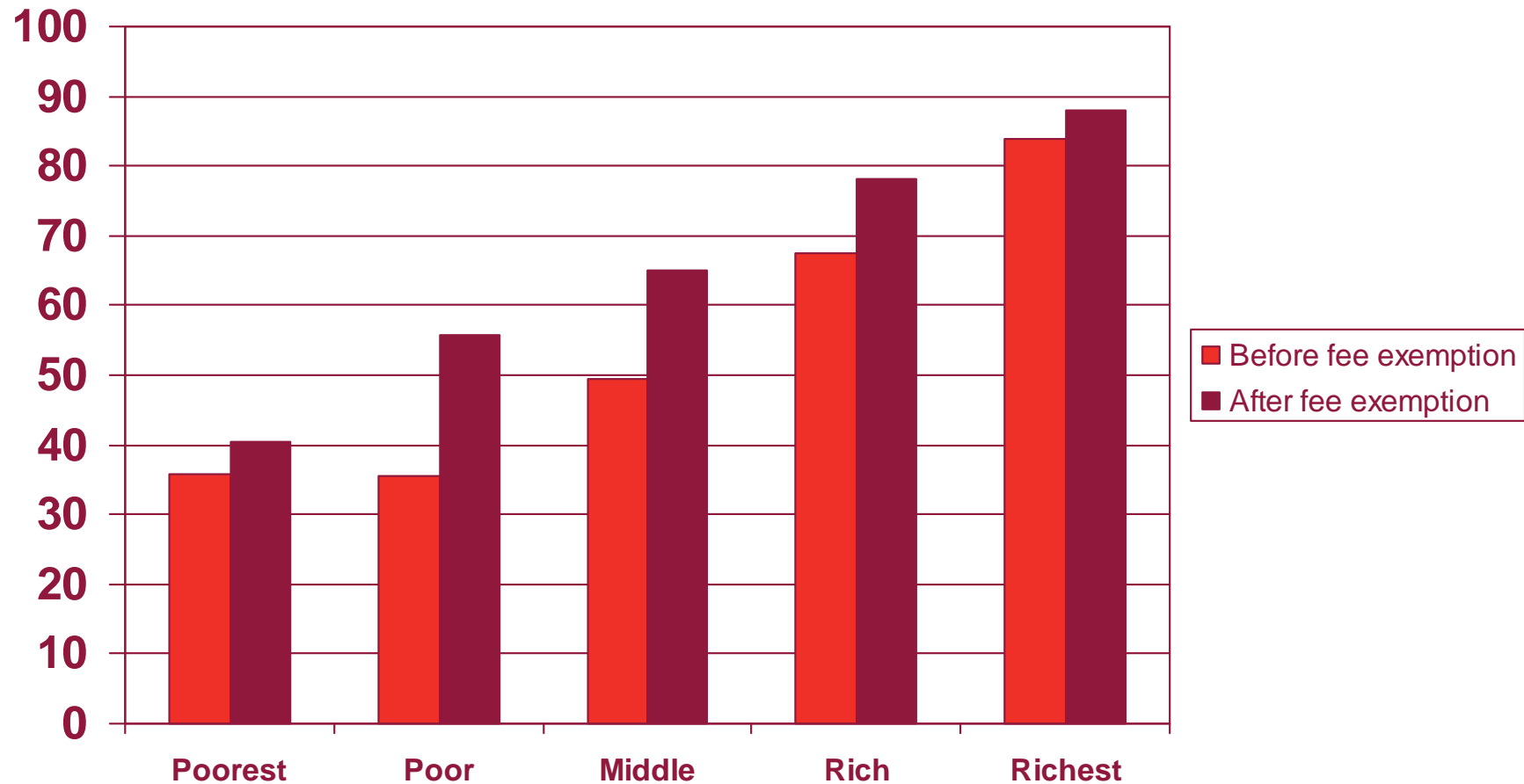
Lessons emphasise potential of exemptions approach but also nuts-and-bolts issues such as proper budgeting, communication, implementation. Also difficulty of reaching poorest (as opposed to poor).

For more details see:

Witter, S.; Adjei, S.; Armar-Klemesu, M.; Graham, W. (2009) **Providing free maternal health care: ten lessons from an evaluation of the national delivery exemption policy in Ghana.** *Global Health Action* 2009 DOI:10.3402/gha.v2i0.1881

Ghana: coverage gap reduced but still substantial despite fee exemption for delivery

% of deliveries in health facilities by wealth quintiles



NB. Delivery fees reduced by 28% on average for caesareans & 26% for normal deliveries (Impact data)

Janani Suraksha Yojana vouchers, India, 2005 – payments conditional on 3 ANC visits and facility delivery. Increase in number of deliveries covered, but concern about transparency of cash flow and payments for home deliveries

Nepal exemptions and transfers, 2006 – national scheme with components of payment to facilities, to HWs and to women. Independent evaluation (Powell-Jackson, 2008) found slow implementation, issues of financial management, but evidence of increased institutional deliveries, especially for the middle wealth group. Some distortions too (e.g. abuse of payments to HWs for home deliveries)

Tend to be targeted towards poor; many include a component covering non-facility costs; some national, others smaller coverage; typically higher overhead costs; few independently evaluated yet

Some recent examples:

- Yunan, China, 2001
- Bangladesh, 2007
- Kenya and Uganda for FP and delivery care, 2007
- Cambodia vouchers for all maternal health care: expanding coverage but concern about targeting and about low utilisation (<50% of women receiving vouchers used them)

Variety of schemes in West Africa which provide loans for emergency obstetric transport and/or fees

Some success documented, but generally small-scale

Clearly only has ability to smooth expenditure, not to mitigate costs (so likely to be complementary strategy)

- Nouakchott obstetric insurance, 2002 – flat rate payment has increased facility deliveries and increased CS rates at participating institutions (but no population data)
- Survey of CHI for emergency obstetric care concludes that has potential to take on ‘additional’ costs which typically not covered by national fee exemption, BUT coverage remains low (non-affordability of premia)
- Supported by study of MURIGA in Guinea (basic and complicated delivery costs) – increasing coverage by area but low in % population covered (<10%)

Wide variety of designs: some paying; others free or subsidised. Some targeted; some universal. Not common yet in sub-Saharan Africa, though some countries are now trying to establish them (e.g. exemptions via NHIS in Ghana since July 2008)

Bolivia MCH insurance, 1996 – free provision for pregnant women and children, funded from national and local sources

Results: significant and sustained increase in access, including for poor (established by independent evaluations). However, there is still low coverage of some services and continued inequalities between urban and rural areas

Indonesia Askeskin, 2005 – insurance for poor, including maternal care

Results: high take-up for hospital care (51% and 73% of women delivering at district hospitals in Impact areas) but low at community/midwife level (only 25% of village midwives use it), according to Impact research



- Need for clear M&E plan – limited data on scale of utilisation increases, never mind costs and distribution of benefits
- Need for clear implementation plans and guidance – some big divergences from original objectives
- Typically trade-off between scale and depth of package; also between scale and uniformity of implementation
- Concern about low take-up in some schemes, despite apparent benefits to households
- Need to consider impact on HWs & involve them in planning changes
- Need for longer term follow-up and planning of complementary measures

Obstetric finance scheme	Cost of intervention	Impact on utilisation
Bolivia social health insurance	Not reported	Supervised deliveries rose nationally from 43% to 60% over period 1994-2003, partly related to SUMI. CS rose from 11% to 16% over same period (though no change in rural areas).
Burkina cost sharing	Estimated \$165 per CS	20.3% increase in supervised deliveries between 2003 and 2007 1.2% increase in CS
Cambodia vouchers	\$5 per voucher recipient	Not yet established
	\$18 per supported delivery	
Ghana fee exemption	\$22/delivery (all types) \$0.16 per capita (nationally) \$62 per <i>additional</i> delivery (all types)	12% increase in supervised delivery rate (2003-2005, Central Region) 5% increase (2004-5, Volta Region)

Costs and impact (2)

Obstetric finance scheme	Cost of intervention	Impact on utilisation
India cash transfer	Not reported	Between 15 and 27% increase (depending on the areas) in facility deliveries
Mauritania EmOC insurance	Premium of \$22 per pregnancy	33.8% increase in facility deliveries (but may be some switching)
Muriga CHI, Guinea	Not reported	5% increase in supervised deliveries (2000-2006) 1.1% increase in CS (not different from non-MURIGA areas)
Senegal fee exemption	\$2.2 per normal delivery \$154 per CS \$0.10 per capita nationally \$21 per <i>additional</i> normal delivery \$467 per <i>additional</i> CS	Based on sample of facilities in five exempted regions (2004-6): 4% increase supervised deliveries 1.4% increase in CS rate

Short answer: no!

Different schemes share more than divides them

While the policy design matters, the details of implementation and the interaction with context matter even more

The policy should be based on a **thorough situation analysis** of the main barriers to raising skilled delivery

Policies directly addressing financial barriers are most appropriate where there is:

- High maternal mortality (and/or high inequalities in maternal mortality rates by area or socio-economic group)
- Relatively low skilled attendance rate at delivery (and/or high inequalities in skilled attendance at delivery rates by area or socio-economic group)
- Low caesarean rates (below 5% of all deliveries) and/or high inequalities in CS rates by area or socio-economic group
- Physical access by population to health care facilities
- Staffing of health facilities with at least minimum norms of trained personnel
- Acceptable quality of care, with functioning equipment and adequate drug supply
- High out-of-pocket payments by households for delivery care, relative to household income

- The package of services to be covered should address the policy's objectives (e.g. including the interventions which save lives and cause most economic hardship to families)
- The policy should be consistent with the wider policy environment and thinking in government
- The policy should extend to major service providers, whatever their sector of work, reflecting current utilisation patterns
- Eligibility should reflect areas of greatest need but also a realistic assessment of available resources (roll out in pro-poor way)
- Additional investments should be planned alongside the policy to address key supply-side constraints (such as staff shortages) and to cope with increased utilisation in the medium-term

- The scope for additional demand-side investments, such as in transport funds, should be considered alongside supply-side approaches, in specific areas of need
- The role of complementary players, such as TBAs, should be considered - can they be involved in the policy in a constructive way?
- Policies should reinforce the referral process, so that uncomplicated deliveries are handled at lower level facilities
- Conversely, the policy should support access to referral care for those with medical needs

- All key stakeholders should be consulted and involved in development of the policy. This process should engage with potential ‘champions’, who can sustain the policy momentum nationally and sell the policy politically
- The policy should be carefully and realistically costed and matched with likely funding sources (projected to assess likely changes over the medium-term)
- Policy guidelines should be clearly elaborated and communicated to all key stakeholders
- Policy should be subject to periodic review and revision with major stakeholders

- Core messages should be kept as simple as possible
- Strategy should be developed for active dissemination of policy to communities and health workers
- Statements of benefits package and eligibility criteria should be prominently displayed



- Funds should be allocated by area according to a population-based formula, adjusted for service utilisation rates and case-mix
- Other public funding sources should be maintained so that the policy provides additional resources
- Funding should be regular and predictable

- The payment mechanism should ensure that average production costs (or the components that are not centrally funded or subsidised) are reimbursed (but not over-reimbursed) for each provider type
- Payments to facilities should *either* be made in advance, based on predicted caseload, and adjusted periodically, based on reports, *or* paid retrospectively but frequently, to avoid cash-flow problems
- If based on activities, there should be record-keeping which allows for independent verification of cases managed

- Indicators of cost escalation, including caesarean rates, should be monitored, and incentives adjusted to counter-act over-medicalisation
- The financial impact on health facilities should be monitored, with checks to ensure that costs are not being shifted onto other services, or into informal payments
- If health workers were dependent for part or whole of their income on user fees, then compensatory measures should be built into the policy

- There should be clear lines of responsibility (both institutional and individual) for managing and monitoring the policy implementation process
- Timely monitoring should pick up and respond to problems, but also flag up successes to generate continued financial support
- Periodic community-based surveys should assess actual benefits to different socio-economic and geographical groups
- Evaluations should be conducted periodically, using baseline indicators of utilisation, quality of care, health outcomes and household costs
- Country experiences should be documented and shared, focussing not only on costs and outcomes, but also on the processes which enabled policies to be sustained and to be effective, or conversely, which acted as barriers

Addressing financial barriers is an important component of the package needed to meet the MDGs

It is affordable, if the commitment is there (e.g. 2.5% of recurrent health budget in South Africa, to provide free MCH)

There is no one right approach, but key ingredients for success include:

- local commitment
- perseverance over time
- a holistic approach which addresses demand- and supply-side barriers
- maintaining a focus on universal coverage as the ultimate goal



Thank you!

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