Learning lessons and moving forward: how to reduce financial barriers to obstetric care in low-income contexts

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Introduction: typology of interventions

In all of the contexts described in this book, the problem statement is the same - few women are accessing formal delivery services, for reasons which include their inability to afford the cost of care. Skilled attendance rates, nationally, range from around one-third in the case study countries with the highest proportion living in absolute poverty to two-thirds in those with the lowest levels (Table 1). All, apart from Bolivia, have caesarean section rates that fall far below the recommended range of 5%-15% of deliveries (and in Bolivia, the low rural rates are counterbalanced by excessive urban one).

The financial barriers that they face stem from a range of factors, including low household incomes, low prioritisation of maternal health within the household, high costs of care, unpredictability of costs of care, and lack of risk-sharing mechanisms within the health financing system (so that the majority of costs are paid out-of-pocket by households). The financial and non-financial barriers result in low demand for obstetric care and low effective access. Although interconnected, some of these barriers are addressed more directly through health system interventions and others through household and community interventions (Figure 1).

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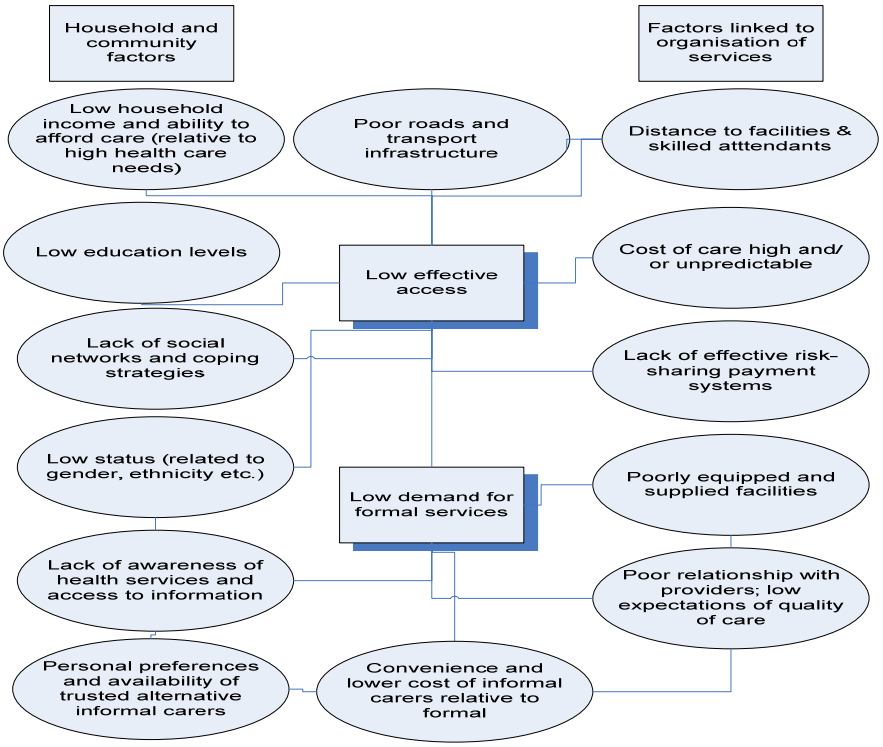
Table 1. Selected characteristics of cases study countries

Country	GNI per capita in current US$ (2007)	National skilled attendance coverage (DHS)	C-section rate (DHS)			Out of pocket as % of total expenditure on health (2007)	% population below 1.25 US$ per day
			Total	Urban	Rural		
Bolivia	1,260	67% (2003)	15.8	23.0	6.1	32%	19.6% (2005)
Burkina Faso	430	38% (2003)	0.7	2.6	0.4	44%	56.5% (2003)
Cambodia	540	44% (2005)	2.2	6.7	1.4	63%	40.2% (2004)
Ghana	590	47% (2003)	4.2	8.9	1.8	45%	30.0% (2005)
Guinea	400	38% (2005)	1.8	5.2	0.8	88%	70.1% (2003)
India	950	47% (2005-2006)	9	17.3	6.2	78%	Rural 43.8% (2004) Urban 36.2% (2004)
Mauritania	840	57% (2000-2001)	3.3	5.6	1.5	31%	21.2% (2000)
Senegal	820	52% (2005)	3.5	7.1	1.4	56%	33.5% (2005)

Sources: World Bank (key development data & statistics), Countdown 2015 (Country profiles), DHS Stat Compiler

Figure 1. Barriers for households to accessing obstetric care (source Witter 2008a)



The interventions described in this book aim to lower access barriers by averting some of the economic and social costs of paying for obstetric care which are described in the context chapter (Borghi *et al.* 2008). Cost structures vary according to context, with facility costs dominating in some contexts and non-facility costs (for example, for transport) dominating in others. The costs of obstetric care take many forms and are not just focussed on the intrapartum period, but can also last for some time after the delivery, particularly in the event of an obstetric emergency or near-miss event (Storeng *et al.* 2007).

Most of the approaches described in this book focus on the cost of care and on increasing risk-pooling of costs. They mostly adopt one or more of the direct strategies to reduce financial barriers to care described in Table 2.

Table 2. Direct strategies to reduce financial barriers - an overview

Strategy	Funding	Targeting	Which costs?	Purchasing	Payment systems
Supply side (financial barriers tackled via the health system)					
Fee exemption or reduction (Ghana, Senegal, Burkina)	Public finance or donors	Service-based; possible geographic targeting and self-selection	Official fees for services and goods	Health facilities - public, private, private not-for-profit	Subsidies on inputs or retrospec-tive payment per case to facilities
Waivers (Cambodia HEF)		Individual or household targeting			Payments per case or per capita to facilities
Tackling informal payments (Mauritania)	User fees, with possible subsidy component	All services within specific facilities or facility types			Internal to facility budget: substitution of official for unofficial payments
Demand side (financial barriers tackled directly via the households)					
Conditional cash transfers (India)	Public finance or donors	Individual or household targeting	Any cost compon-ent, potentially - fees, transport, food, opportunity costs	Usually third party organisation, based in community, or at facility, or indepen-dent (but generally not-for-profit)	Payment to client, subject to specified attendance at facilities
Vouchers (Cambodia)	Public finance or donors, with possible co-payments	Individual or household targeting, usually, though could be geographic	Official fees for services and goods		Payment per case to facilities in exchange for redeemed vouchers
Loans	Public finance, donors, community contribu-tions	Individual and needs-based (sometimes based on creditworthiness too)	May be restricted to certain costs or situations, or general		Loans to clients with or without fixed limits and interest
Prepayment/ community health insurance (Guinea, Mauritania)/social heath insurance (Bolivia)	Public finance or donors, with possible co-payments	Individual or household targeting, usually, though could be geographic	Official fees for services and goods		Subsidy payment to insurance fund per target client enrolled

Source: adapted from (Witter 2008b)

In addition to direct approaches to reducing financial barriers, there are a variety of actions which, while not usually framed in those terms, do in reality bring down the real costs of accessing services for clients. These include, for example:

- Changes to public resource collection and allocation in such a way that poorer areas benefit and are able to pass on the benefits in the form of fee reductions or quality improvements.
- Any policy which increases the income of clients, particularly the poor, will have the effect of reducing the real cost of accessing care (e.g. micro-credits).
- Bringing services closer to clients, which has the effect of reducing transport and opportunity costs (e.g. increase the number of CEmOC facilities or/and provision of funded ambulance service).
- Improving the quality of care and the provision of drugs and supplies similarly reduces real costs to clients, by removing the need to seek alternative sources of care (e.g. in the private sector) and to purchase additional inputs, such as drugs and supplies, which are lacking in facilities.

Lessons derived from case studies

A summary of the policies described in this book and their impact is given in Appendix 1.

Senegal and Ghana present examples of national fee exemption policies, which have achieved positive results at relatively low costs per case, but with significant implementation difficulties. These included inadequate funding in Ghana and failure to adequately reimburse lower level facilities in Senegal, both of which reduced the real benefits which were realised for households (Witter *et al.* 2008c). These policies were wide but thin: entitlement was universal, with rapid scale up from poorer regions, but with theoretical cost reductions limited to service fees, while the bulk of household expenses go to drug costs and transport. Community health insurance (CHI) could play a complementary role by taking on these costs not covered by the national fee exemption policy. However coverage of CHI remains low and access is not guaranteed if households cannot afford the premium (Soors *et al.* 2008). In Guinea, a CHI was developed specifically to protect women and their families from excessive expenditures (Ndiaye *et al.*

2008). This system, called MURIGA, is progressively scaling up in terms of district coverage but the the proportion of adherents remains low, as is common for more general CHI.

In Mauritania, household solidarity is expressed by a flat fee pre-payment scheme. This prepayment is offered to pregnant women at the first antenatal consultation and covers all costs until the end of the pregnancy. The state pays salaries to the health personnel involved in the obstetric care and the pre-payment covers consumables and fees. This is a district-managed scheme (Renaudin *et al.* 2008). The Burkina initiative in Secteur 30 includes all care for the mother and her newborn (transport, intervention and post-delivery care) but is limited to emergency and/or life-threatening obstetric care. This scheme involves not only the district, the households and the health centres, but also the local authorities. This system is district-driven and cannot be implemented without the willingness of the district team and local authority (Ouédraogo *et al.* 2008).

Other approaches target the poorest pregnant women. In Cambodia, a voucher system and a Health Equity Fund (HEF) were implemented with the specific aim of protecting the poorest. The number of voucher and HEF beneficiaries represented a large share (32.5%) of total reported facility deliveries and increased sharply over time. But the study questions the effectiveness of the targeting (Por *et al.* 2008). In India, the government introduced a conditional cash assistance programme called the Janani Suruksha Yojana (JSY) in 2005 to promote institutional deliveries. Under this programme, poor women who attended three antenatal clinics and who delivered in a health facility were to be given money soon after delivery to take care of their direct and indirect costs (Devadasan *et al.* 2008). Process evaluation shows the difficulty of assuring efficient and transparent cash transfers in a policy of this ambitious scale.

In the case of Bolivia, a variety of packages for free care have been developed over the past decade, promoting access for priority groups such as mothers and children. Although these are called social health insurance, they are funded not by membership but by national and local revenues, and to that extent are similar to the national exemption policies. A significant and sustained increase in access has been achieved, but overall coverage of services remains low and indicators for rural areas still lag far behind those of urban areas (Pooley *et al.* 2008).

There are a number of lessons which emerge from these case studies. One is the importance of setting out a clear monitoring and evaluation framework for new policies. Given the frailty of funding for many of these policies, robust evidence of results is needed to justify further external investment. It is also important to look at beneficiary incidence - how much of the subsidies are reaching the poorer households. Few schemes do this at present (only Ghana out of the case studies in this book).

The need for clear implementation plans and guidelines also emerges for some of these initiatives. Differences have been observed in terms of implementation that can lead to a complete distortion of the objectives of the plan (for example, in India, where some areas decided to reimburse home deliveries). This has also been noted in similar policies elsewhere (Powell-Jackson *et al.* 2007).

Funding sources vary greatly between schemes - some rely fully on national government funding (Ghana, Senegal, India); some are fully funded by donors (Cambodia); some are mainly funded by users (Mauritania); and others have a mix of sources (three levels of government in Bolivia; a mix of users, local government and national in Burkina). Many had considerable assistance with set-up costs from donors (Mauritania and Guinea). Funding sources correlate to some extent with the scale of the policy: those funded by government are much more likely to be national in scale, compared to other sources. They are also most plagued by funding delays.

The low take-up of some of the benefits packages - even where these are substantial and do not require co-payments by households - merits further investigation. In the Cambodia voucher scheme, less than half of the eligible women used their vouchers for delivery care. In Guinea, a 10% take-up rate was reported, despite the high external subsidy and potentially large cost-savings for households. These imply non-financial barriers, such as concerns over quality of care or geographical and cultural barriers.

A theme shared by most of the studies is the dissatisfaction of health workers with rising workloads and the lack of income supplements (with the exception of Mauritania) - though in some (such as India) informal payments may be filling the gap. To ensure the sustainability of the policy and to minimise adverse effects, this constituency should be won over in reforms to user payments. This is likely to involve a mixture of measures, including consultation over changes, improvements to pay and working conditions, and ensuring adequate staffing and controls over working hours.

All schemes report increased uptake of services, though few have robust evidence of the extent of the increase (see Table 3). Costs of intervention are equally under-reported, but where this information is available, the estimates are fairly close (for example, $18-$21 per normal deliveries and $154-$165 per CS). These costs do mask differences in benefit packages though.

Table 3. Summary of costs and utilisation responses

Obstetric finance scheme	Cost of intervention	Impact on utilisation
Bolivia social health insurance	Not reported	17% increase in supervised deliveries at national level over period 1994-2003, partly related to SUMI. 5% increase in CS 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 (secteur 30 district)
		1.2% increase in CS
Cambodia vouchers	$5 per voucher recipient	12.3% increase in public health facility deliveries (2006-2007-
	$18 per supported delivery	(increase of vouchers deliveries as well as self paid deliveries)
Ghana fee exemption	$22 per delivery (all types)	12% increase in supervised delivery rate (2003-2005, Central Region)
	$0.16 per capita (nationally)	5% increase (2004-2005, Volta Region)
	$62 per *additional* delivery (all types)	
India cash transfer	Not reported	Between 15 and 27% increase (depending on the areas) in facility deliveries (2004-2006)
Mauritania EmOC insurance	Set-up costs of $1.3 to $4 per reproductive age woman	33. 8% increase in facility deliveries (2000-2007)
	Premium of $22 per pregnancy	
Muriga CHI, Guinea	Not reported	Little impact on supervised deliveries : 5% increase from 2000 to 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 *additional* normal delivery $467 per *additional* CS	Based on sample of facilities in five exempted regions (2004-6): 4% increase supervised deliveries 1.4% increase in CS rate

Most of the policies described here were young, and so the impact on more 'fixed' costs, such as staff, equipment and maintenance were not significant, but over time, as activity levels increase, governments must budget for increased allocations to these areas.

There is a clear trade-off between depth and breadth, with targeted schemes (Cambodia, India) able to include a wider range of costs, such as access costs. However, the assumed equity advantages of individual targeting over geographical targeting was questioned by the Cambodia case study, which highlighted the problem of maintaining systems for identifying the poor in all villages.

Some of the initiatives had very short lifetimes, being soon superseded, fully or partially, by new policy initiatives (e.g. in Ghana, by the shift from exemptions to national insurance, or in Burkina Faso, by the shift from localised cost-sharing to a national subsidy policy). These policy shifts can be positive, if they represent scaling up of policies and are based on lessons learned from previous experiences.

The only case study with a longer history (of more than a decade) is the Bolivian one. It demonstrates the possibility of improving national indicators with sustained national commitment over time, but also issues of cost-control, and the limit to policies which target financial barriers alone, without addressing wider health system, geographical and cultural barriers.

The case studies highlight a range of practical lessons on the implementation of policies aimed at reducing financial barriers to obstetric care. These are summarised in Box 1.

Box 1. Lessons on implementation of policies to reduce financial barriers to obstetric care

1. Design of policy

- The policy should be based on a thorough situation analysis of the main barriers to raising skilled delivery (financial barriers may not be the most significant factor in some contexts). 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 of services and subject to minimum quality standards
- Eligibility should reflect areas of greatest need but also a realistic assessment of available resources
- 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

2. Policy development process
- 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 (based on utilisation patterns, caseload, unit costs, and projected changes to these) and matched with likely funding sources (also 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

3. Policy dissemination
- 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

4. Resource allocation
- 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

5. Payment systems
- 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

6. Management, monitoring and evaluation

- 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

Is there a best bet strategy for different contexts?

There is increasing recognition of the importance of context and process, which will determine the dynamic responses of health systems to changes. A three-country study of health reforms and maternal health (Penn-Kekana *et al.* 2007) found large differences between de jure systems (as laid out in official documents) and de facto systems (in terms of actual care). Informal behaviours, structures and relationships mediated the official policies in unintended ways which sometimes worked against their purpose. This limits the transferability of lessons (positive and negative) from one context to another.

It is also widely recognised that there is no single successful way to 'target' the poor (Gwatkin *et al.* 2005), and that many different approaches are required to re-orient health systems towards greater equity. A recent report for WHO included wide-ranging recommendations covering political and legal frameworks, regulatory measures, health financing and management initiatives (Gilson *et al.* 2007). Others go even broader, and emphasise that equity should involve addressing the root causes of poverty and inequity, not just addressing the symptoms: ' "Pro-poor" interventions deployed around a deeply inequitable core structure are insufficient' (UN Millennium Project 2005). There is a growing view that health systems should not just seek to guarantee equitable access to interventions but

should be seen as a core social institution which reinforces social solidarity and citizenship. Conversely, exclusion and marginalising treatment by the health system is increasingly recognised as forming a core part of the experience of being poor in low-income countries (UN Millennium Project 2005). The authors of this report argue for a paradigm shift away from the focus on competitive markets to deliver health care goods more efficiently to a human rights approach which recognises the role of the state in ensuring redistribution and social solidarity. This involves reinforcing the legitimacy of the state, strengthening collaborative relationships between public and private sectors, and giving the poor a stronger voice and power to assert claims.

Financing increased coverage

The overall financial climate remains highly constrained in low-income countries. Many countries spend less than $10 per capita per year on health care, which is well below the ballpark figure suggested by the Commission for Macroeconomics and Health (CMH) of $35-40 to finance a basic package of health in developing countries (World Health Organization 2001). Some are pessimistic about the likelihood of reaching that figure in the period to 2015 (Pearson 2007). These projections suggest that health financing is likely to increase over the period to 2015, but will be lowest and starting from the lowest base in the poorest countries, and unlikely to reach CMH targets. Even if the Abuja targets for government allocations to health were met (15% of public expenditure allocated to health), there would continue to be significant shortfalls in funding, relative to the $35 per capita target. Consequently, this report argues, the focus should be on improving the use of such additional resources as are realistically to be expected.

A recent modelling exercise of the additional resources required to reach the MDG goals for maternal and newborn health in 75 countries produced estimates of $39 billion over the next ten years to achieve moderate scale up, and $56 billion for a more rapid scale up (Johns *et al.* 2007). Mobilising these resources will be challenging, despite recent initiatives, such as the Global Business Plan for MDGs 4 and 5 and the International Health Partnership. Estimates of the cost of reaching MDG 5 in high-burden countries range from $0.22 per head to $1.40 (Gill *et al.* 2007). Based on 2004 levels, donor funding would have to increase 11-fold to achieve the

investment which the WHO estimates is needed by 2015 (Borghi *et al.* 2006; Powell-Jackson *et al.* 2006). A recent review of donor funding found that funding for maternal and neonatal health had increased between 2003 and 2006 from $7 per live birth to $12 per live birth (Greco *et al.* 2008). However, the authors noted that funding has reduced in some high-burden countries and that resources were not well targeted to areas of highest maternal health need.

Maternal health is also in competition for resources with other health goals, and has traditionally attracted fewer resources than the more 'vertical' interventions, though this is something that the recent initiatives aim to address. The relatively modest cost of providing free mother and child care in countries like South Africa - 2.5% of the recurrent budget (Schneider & Gilson 1999) - suggest that resources for this strand could be found at the national level, if this was seen as a priority intervention by policy-makers. Recent initiatives, such as the Partnership for Maternal, Newborn and Child Health have attempted to act as advocates for MCH and to create harmonised messages - one of the weaknesses identified by some observers of the Safe Motherhood movement (AbouZahr 2001, Shiffman & Smith 2007).

International financial support is currently being pulled in two directions. One is towards strengthening health systems, with the recognition that high levels of funding tied to specific diseases can weaken the sector as a whole. For example, a recent report found that only about 20% of all health aid goes to support the government's overall programme (i.e. is given as general budget or sector support), while an estimated 50% of health aid is off budget (Foster 2005). On the other hand, there is a shift towards output-based aid, in which aid is dependent on specified targets being met (World Bank 2007). Depending on how, by whom and which targets are set, these approaches may or may not reinforce one another.

Conclusion

There is renewed interest in closing the gap in skilled attendance and maternal health, between and within countries, and a variety of approaches have been tested in recent years in different contexts. In addition to policies which directly address the financial barriers for households, which are the focus of this volume, there is also a growing interest in complementary areas, such as getting the right incentives for health workers to increase coverage

and creating aid modalities which enable and reward higher performance by the health system as a whole. These approaches can all contribute, if designed in an integrated way, to meeting the MDG goals.

Adopting the right package for a given context is not a mechanistic matter. The balance of supply- and demand-side constraints will vary, and the design of an appropriate policy has to take into account resource availability, cultural expectations of roles and responsibilities, as well as the way in which the health service is financed and organised.

There are no single 'best bet' strategies for all contexts, but there are established pathways to success, derived from country experiences. The key ingredients are local commitment, perseverance over time, a holistic approach which addresses demand- and supply-side barriers, and maintaining a focus on universal coverage as the ultimate, if not immediate, goal.

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