



# Impact

Financial  
barriers to safe  
deliveries:  
lessons from  
Impact  
research

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- Low supervised delivery rates, especially for Africa
- Barriers include poor geographical access; low education levels; traditional attitudes to deliveries; gender status issues; poor quality services
- Financial barriers significant too – poverty, high cost of services and unpredictability of expenditure
- Lead to two key research questions:
  1. How responsive are users to reduction in costs? (demand side)
  2. How viable, effective and sustainable are different approaches to reducing costs? (supply side)

- Supply-side approach: pay providers up front or retrospectively for providing free or subsidised delivery care for specified group or all women
- Demand side approach: free insurance coverage; vouchers for care; cash transfers to cover service or other costs

Focal country	Policy approach	Who benefits?	Benefits package	Evaluation tools	Status of evaluation
<b>Ghana</b>	Exemption of user fees for deliveries	All women; in poorer regions from 2003 and nationwide from 2004	All deliveries in facilities (but not pre- or post-natal care). Available from public, mission or private midwives. No assistance with other user costs	<ul style="list-style-type: none"> <li>•Household survey</li> <li>•Key informants interviews</li> <li>•Financial flows tracking</li> <li>•Health workers incentives survey</li> <li>•Focus group discussions</li> <li>•Quality of care assessment tools</li> </ul>	Reports completed

Focal country	Policy approach	Who benefits?	Benefits package	Evaluation tools	Status of evaluation
Senegal	Exemption of user fees for deliveries	All women in poorer 5 regions from 2005; some extension for C-sections in other areas from 2006	<ul style="list-style-type: none"> <li>•C-sections in regional and district hospitals</li> <li>•Normal deliveries in health centres</li> <li>•Public sector only</li> <li>•No assistance with other user costs</li> </ul>	<ul style="list-style-type: none"> <li>•Key informants interviews</li> <li>•Financial flows tracking</li> <li>•Focus group discussions</li> <li>•Analysis of utilisation changes and changes to major obstetric interventions</li> </ul>	Fieldwork complete. Data analysis ongoing

Focal country	Policy approach	Who benefits?	Benefits package	Evaluation tools	Status of evaluation
Indonesia	AKES-KIN insurance for poor (via commercial insurance company)	<p>Poorest 10% (based on HH assets).</p> <p>Eligibility assessed by village committee</p>	AKES-KIN covers all facility costs (though not transport), and small payment to midwife for home deliveries	<ul style="list-style-type: none"> <li>•Financial flows tracking</li> <li>•Health worker incentives survey</li> <li>•Census of midwives and cost of posting village midwives</li> <li>•Population-based survey</li> <li>•Cost of care survey</li> <li>•FGDs/In-depth interviews</li> <li>•etc</li> </ul>	Reports completed

Focal country	Policy approach	Who benefits?	Benefits package	Evaluation tools	Status of evaluation
Nepal	Public subsidies for deliveries and transport costs to facilities (arose from study showing high costs)	All women, since 2005-6, but to varying degrees	<ol style="list-style-type: none"> <li>1. Free deliveries in public facilities in low HDI areas.</li> <li>2. Support for women's transport costs, fixed but varying by terrain (all complics; &lt;2 normal deliveries).</li> <li>3. Fixed payment to HW for home and facility deliveries</li> </ol>	<ul style="list-style-type: none"> <li>•Household survey</li> <li>•Key informants interviews</li> <li>•Financial flows tracking</li> <li>•Health workers incentives survey</li> <li>•Focus group discussions</li> <li>•Facility costing</li> <li>•Facility questionnaire</li> </ul>	Protocol prepared with ICH; fieldwork starting

From user side:

- 12% increase in supervised deliveries in Central region (no significant change in Volta – implementation differences?)
- The largest increase in deliveries in health facilities in Central region occurred for mothers with no education (16.3%)
- In Volta region there was an increase in deliveries in health facilities in the poorest quintile only
- Significant decrease in OOP during exemption period for normal deliveries (19%) and CS (22%)
- Significant decrease in catastrophic payments, especially for poorest
- Richer HH costs are reduced by more proportionately than poorer ones

From health system side:

- Hospitals main site for supervised deliveries (30-31%), before and after
- Growth in supervised deliveries mainly at HC level
- In terms of who attended, significant increase in midwife-attended births, and reduction in TBAs
- Under-funding and delays at national level, increasing as scheme goes nationwide
- Poor monitoring of scheme and communication between levels and agencies
- Health facilities benefit while funding is available
- Health workers face increased workload but general pay rising too. Ambivalent attitudes

- Data analysis not complete yet, so can only make preliminary observations
- Lower level facilities receiving kits but no cash, which was source of pay for community staff
- Concerns about adequacy of content and smooth distribution of kits
- Hospitals funds are greater than unit costs of C-sections, but overall in deficit
- National management issues unresolved – accounting, re-ordering, transferring funds, adequacy of budget
- Increased deliveries and CS rates at all levels, but greatest at district level

Some variety of implementation at local level

e.g.:

- Targeting of poorer women only for free CS in Ziguinchor;
- Payments made by women when kits run out in Bakel and Sedhiou;
- In Matam, women paying for ticket, but not for drugs which supplied (only top-up ones)
- In most areas, drugs which are not included in the kits are charged, where needed

Some confusions, by clients, about scope of package

General support, but concerns about sustainability

Ideological differences – does this kind of policy undermine personal responsibility?

Adaptations: e.g. should support CS only?

Relationship with wider demand and supply-side issues (such as staffing shortages, cultural assumptions etc.)

Gender preferences for female attendant?  
(ICP tend to be male)

- Financial barriers are considerable: women admitted to hospital with a near miss spent on average US\$255 (14% of annual income), while home births with a midwife cost an average of US\$51
- Inequities: 76% of the richest quintile gave birth with a midwife or doctor, but only 9% of the poorest. For CS: fewer than 1% of the poor delivered by caesarean, compared to 4% of the rich.
- 20% of poorest quintile borrowing to pay health care costs
- AKESKIN covers 95% of mothers in poorest quintile for hospital deliveries but only 1% in community
- Non-financial barriers to registering: unpredictable nature of emergencies; shame; fear of poor quality care; lack of knowledge and trust
- Financial disincentives to midwives to encourage women to enrol?

- Though overall health expenditure is higher per capita for sub-districts close to district centre, maternal spending is higher in more remote sub-districts
- Total public spending on maternal health care amounts to between \$0.17 (Serang) and \$0.46 (Pandeglang) per capita
- Benefits incidence analysis suggest that the richest 20% of the population benefit from 40% of this funding, while the bottom 20% benefits from only 10% of funding
- Around 35% of earnings of rural midwives are derived from public sources but 58% from private sources
- Does their income-seeking deter poorer households?

- Problems of targeting poor – in Ghana and Indonesia, universal benefits favour all, but rich capture more than their share
- But poor face barriers to accessing targeted help too (AKES-KIN)
- Scaling up and adequacy/sustainability of funds – Ghana and Senegal
- Contrasting health worker markets – dependence on private income vs dependence on public sector pay increases
- Importance of considering impact on facilities (e.g. in Senegal, policy shifts costs from users to facilities – they have taken measures to adapt)

- These schemes address important constraints (price elasticity -0.63 on average for normal deliveries in Ghana): users will respond (even when poorly implemented!)
- There are however many other constraints which require complementary actions
- They require long term and considerable financial support (in Ghana, average costs for Central Region were \$22 per delivery, and this only covers facility costs; costs in Senegal were roughly \$10 per delivery and \$100 per CS)

- Countries need to plan interventions at a sustainable level (which may mean targeting by area, or by delivery type, for example)
- Linked to wider issue of predictable funding for health sector
- Basic management issues need to be addressed so that programme are implemented consistently, and stakeholders can clearly understand the scope
- HW and facility incentives must be aligned with providing care for the poor