



**Scaling up: pro-poor maternal health financing strategies**

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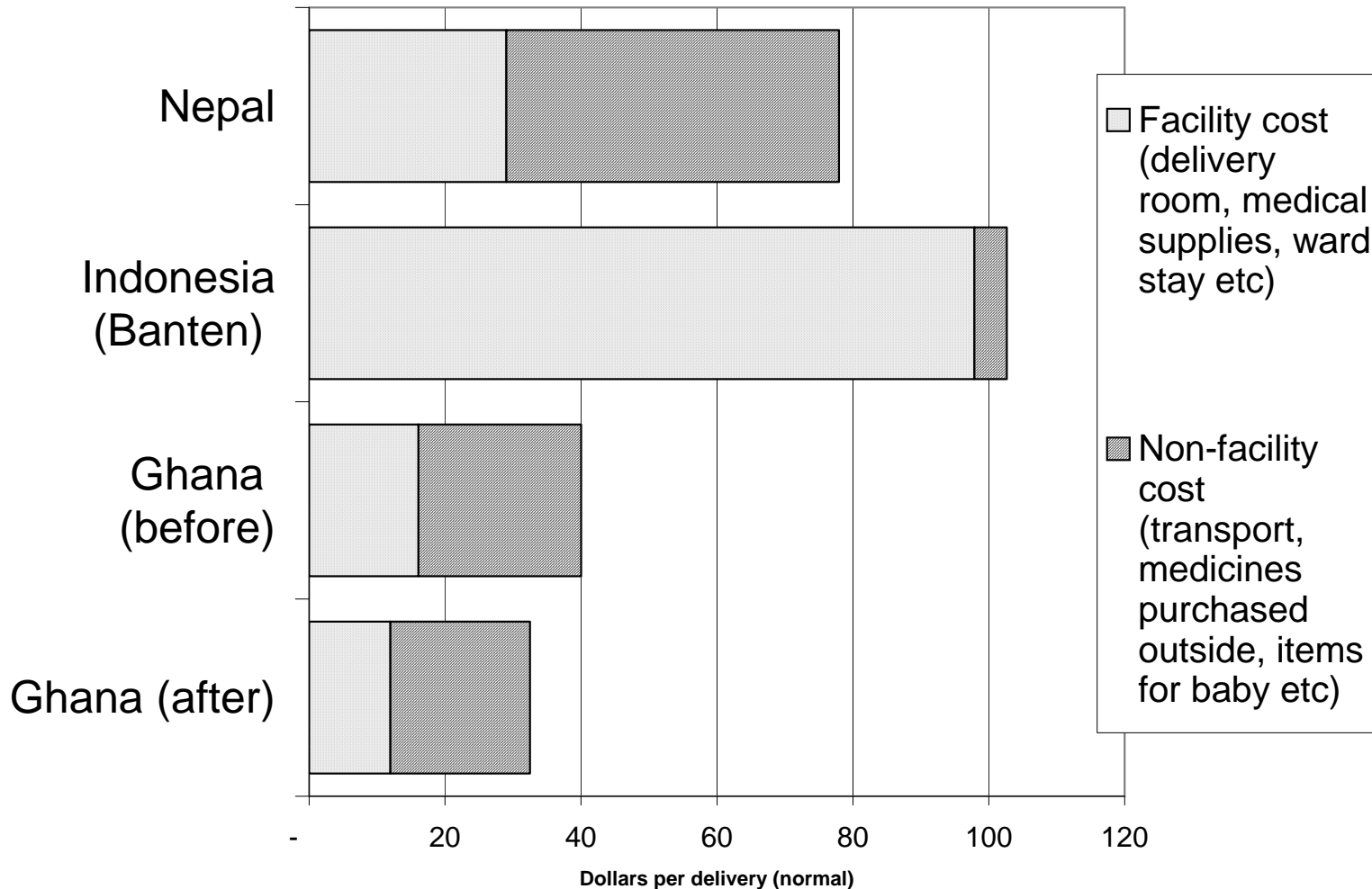
# Scaling up maternal health financing strategies – focusing on the poor



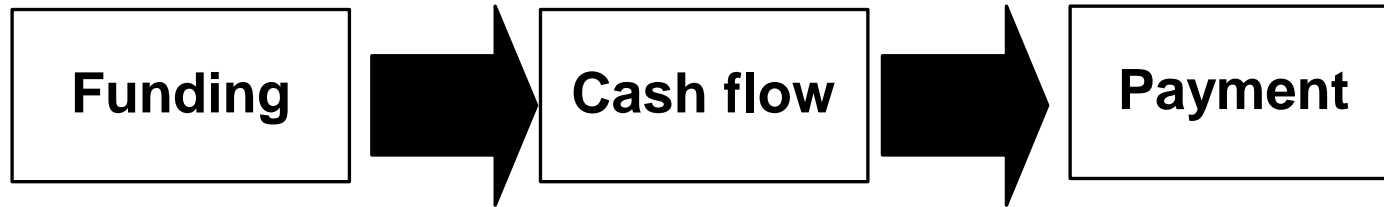
- Much of the burden of maternal mortality and morbidity is amongst the poor Financial barriers are an important (although not the only) obstacle to access
- Making delivery free (at a facility) can help to improve access but may **neither be immediately affordable nor sufficient**
- Based on Impact and other evidence, we look at factors important in informing how to design an affordable financing strategy for delivery care

# 1. Address the most important barrier?

- Scaling up requires an appreciation of the household burden and balance of financial cost
- Different costs are important in different contexts



## 2. Ensure cash flow

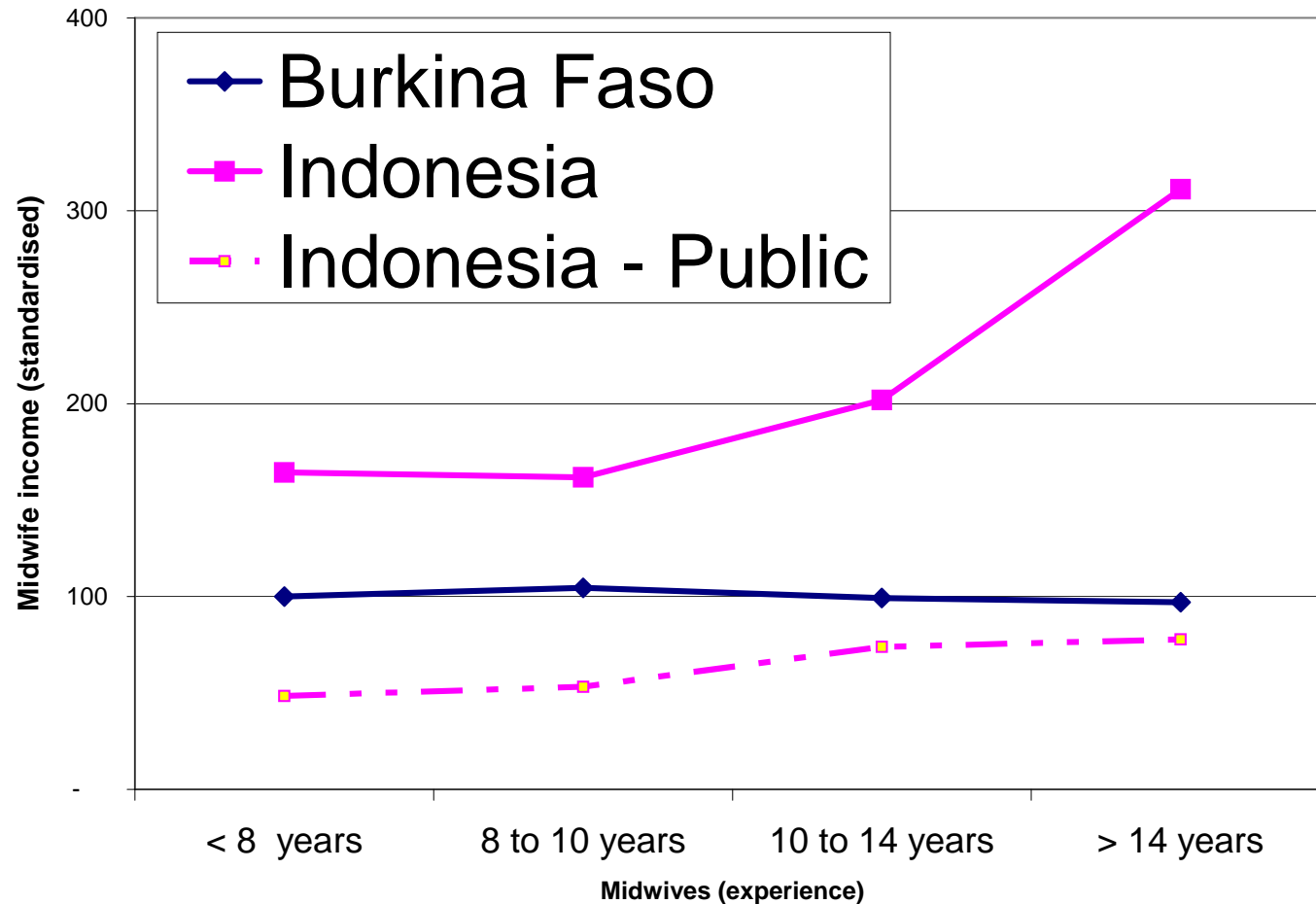


- **Adequate funds** e.g. HIPC funding Ghana, fuel subsidy saving in Indonesia
- Ensure **timely funds flow** –concern in Ghana where user charges have historically been the main regular source of funding.
- **Simple allocation system** for funds - for both identifying beneficiaries and paying providers

**Interventions fail because good basic public finance mechanisms are not in place**

### 3. Practitioner incentives to focus on the poor

What are the incentives to **remain in post** and **serve poorer clients**?



Requires a clear career structure, rewards for working in remote areas and incentives for serving poorer women

## 4. Covering catastrophic maternal health risk

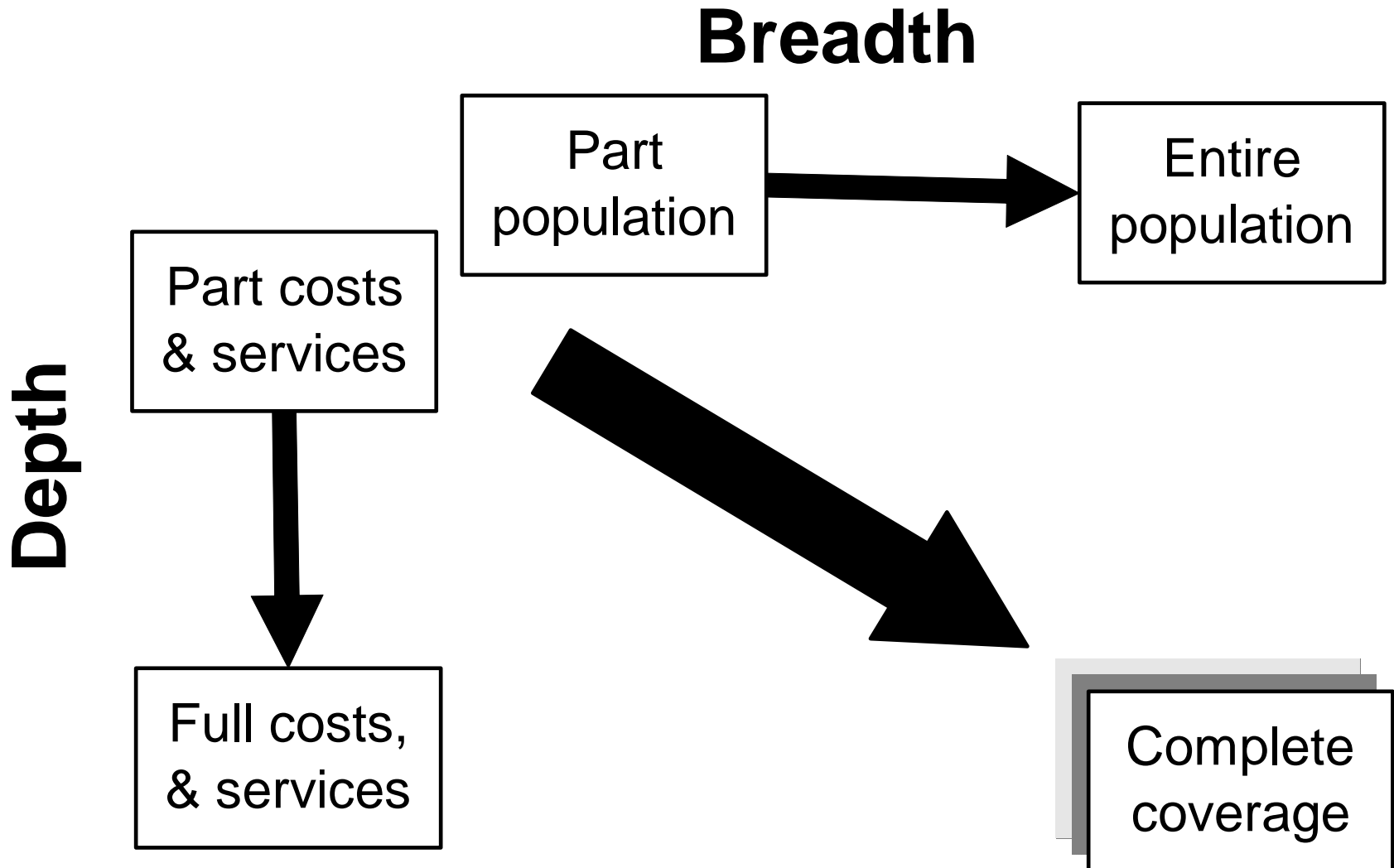


- Catastrophic protection at district hospitals should **not be restricted only to the poor** (e.g. Indonesia - exemptions prevented 13% of households utilising services from being pushed into poverty)
- Communities, even those that are relatively well off, are mostly **unable to absorb costs of emergency care** even where they can finance costs of SBAs.
- Since financing systems affect use of EmOC more quickly than SBA (e.g. Indonesia), access to EmOC may help to bring households into the system

## 5. Universal or targeted?

- Some targeting is inevitable
- **Individual targeting** of services only at the poor appears to be cheaper; but
  - Much mis-targeting and procedures can be expensive
  - Does not protect near poor (previous slide)
- **Categorical targeting** based on **geography**, particularly at a small area level, provides an easy-to-implement approach for SBA e.g. In Indonesia, providing a universal benefit to the poorest third of sub-districts would include 60% of the poorest households.
- Some categorical targeting automatic since women requiring maternal care are more likely to be from poorer than average households

# Dimensions of scaling financing strategies – Breadth and Depth



How best to extend strategies for reducing the main financial barriers?

- A. Main focus of a strategy determined by context. Two key questions:
  - I. Are demand or supply barriers dominant? AN INITIAL FOCUS ON THE MAIN BARRIER (S)
  - II. Is additional investment required to scale up services and ensure quality? A FOCUS ON THE INVESTMENTS REQUIRED TO MEET THE EXPECTED INCREASE DEMAND RESULTING FROM THE REDUCTION IN (FINANCIAL) BARRIERS

## B. Design considerations in scaling up

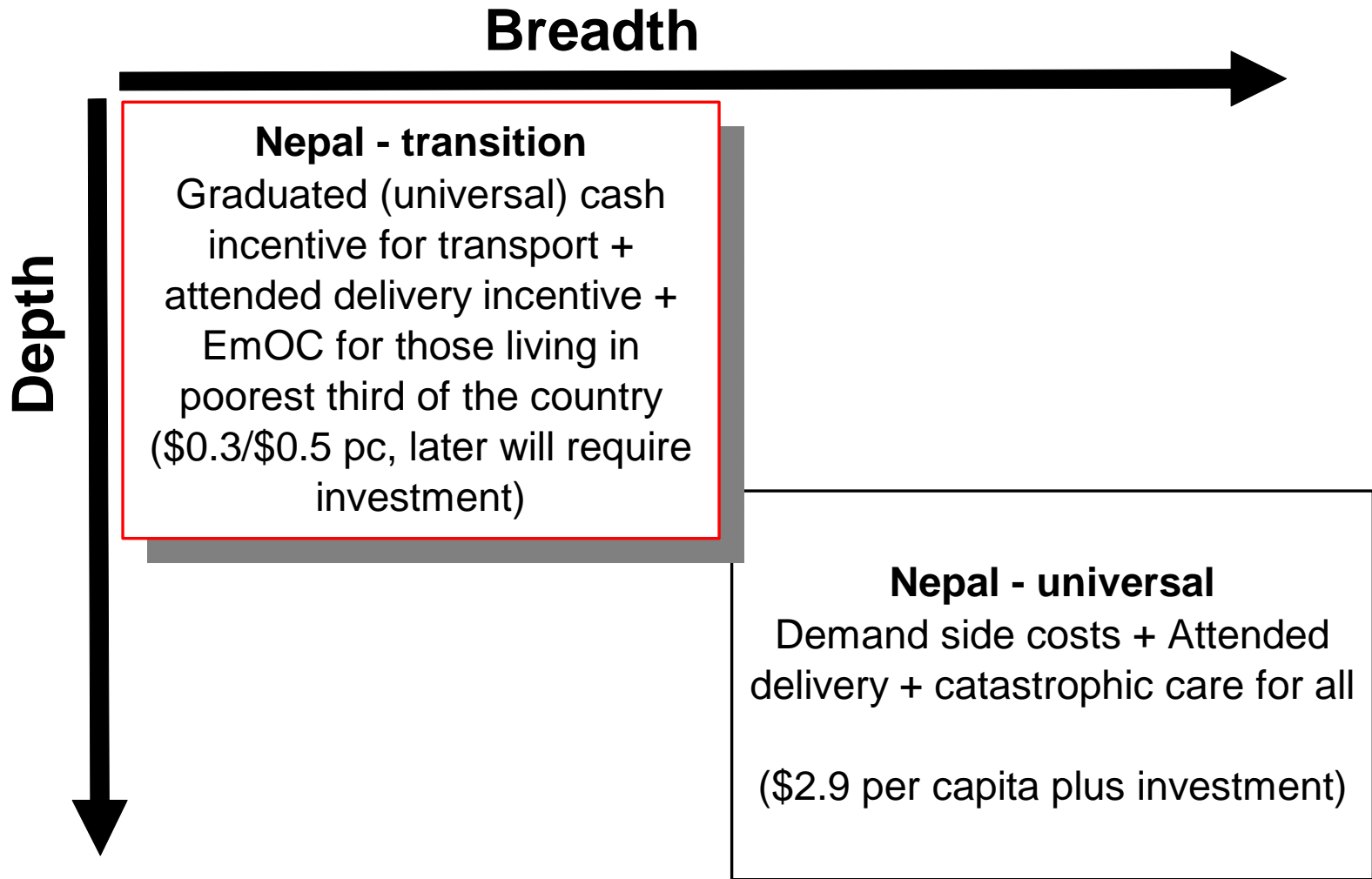
1. Regular and transparent allocation of funding for maternal health care
2. Aim for a simple provider payment system - particularly in the public sector
3. Motivate midwives to deliver services to the poor - career progression and explicit compensation for serving the poor
4. Universal or near universal access to EmOC is essential (**MDG 1 & MDG 4/5**)
5. Category based (Geographic) targeting of small areas for SBA (other than EmOC) as a way to roll-out strategies given financial constraints.

## C. Implementation mechanisms

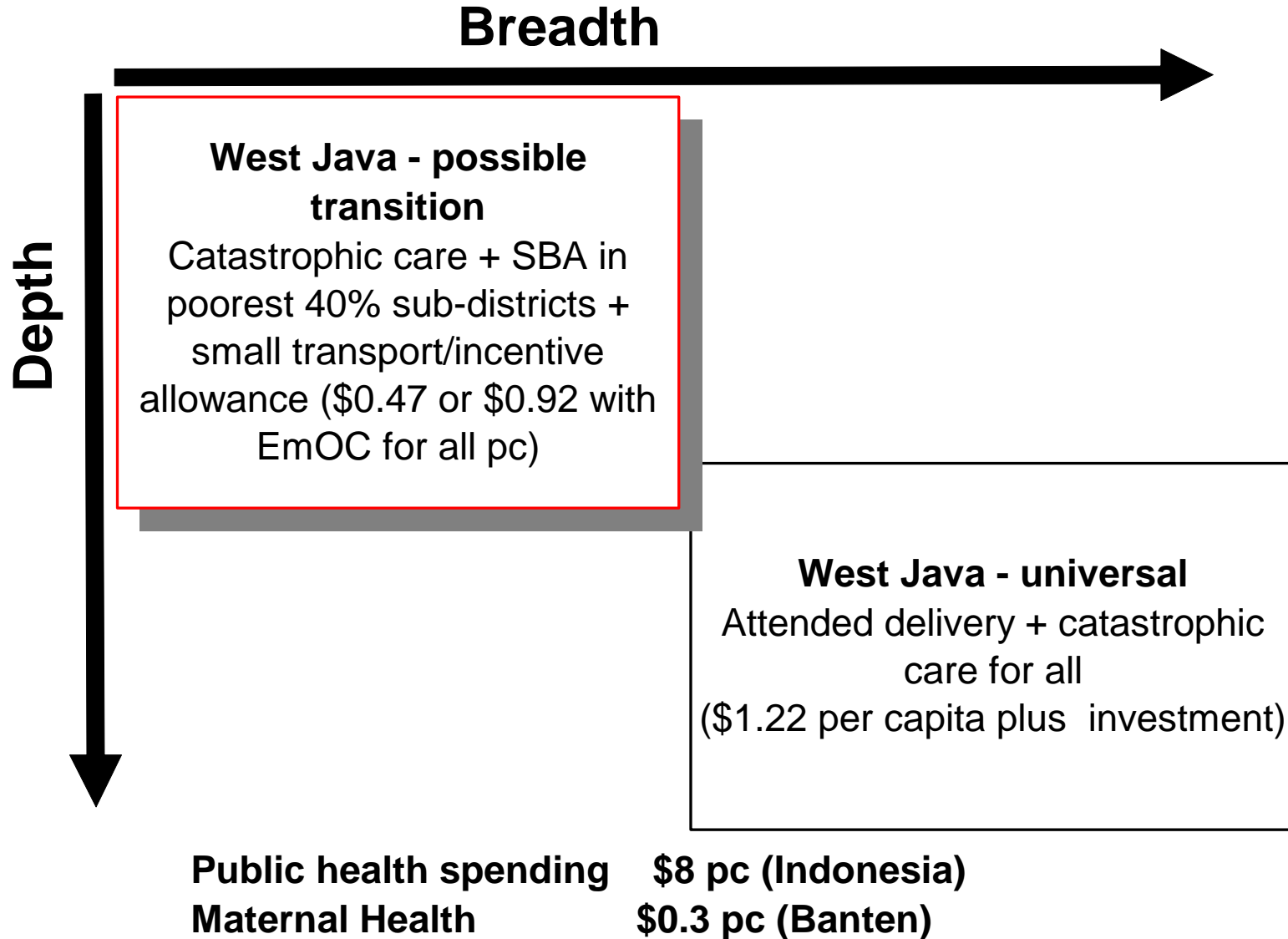
- Input, output, outcome based?

... a couple of examples

# Nepal: An ongoing scaled up strategy



**Public health spending: \$4.06 per capita**





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