Maternal Survival 4

Mobilising financial resources for maternal health

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Coverage of cost-effective maternal health services remains poor due to insufficient supply and inadequate demand for these services among the poorest groups. Households pay too great a share of the costs of maternal health services, or do not seek care because they cannot afford the costs. Available evidence creates a strong case for removal of user fees and provision of universal coverage for pregnant women, particularly for delivery care. To be successful, governments must also replenish the income lost through the abolition of user fees. Where insurance schemes exist, maternal health care needs to be included in the benefits package, and careful design is needed to ensure uptake by the poorest people. Voucher schemes should be tested in low-income settings, and their costs and relative cost-effectiveness assessed. Further research is needed on methods to target financial assistance for transport and time costs. Current investment in maternal health is insufficient to meet the fifth Millennium Development Goal (MDG), and much greater resources are needed to scale up coverage of maternal health services and create demand. Existing global estimates are too crude to be of use for domestic planning, since resource requirements will vary; budgets need first to be developed at country-level. Donors need to increase financial contributions for maternal health in low-income countries to help fill the resource gap. Resource tracking at country and donor levels will help hold countries and donors to account for their commitments to achieving the maternal health MDG.

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The scarcity of resources is a major constraint to ensuring that all mothers receive the interventions they need in a timely fashion. Demand is affected by financial barriers to care-seeking, which interact with geographical and cultural barriers and, combined with inadequate quality of care within the formal health sector, serve to discourage service use.[1] During childbirth, for example, attendants with the skills to respond to complications are present at only half of deliveries worldwide. Also, substantial inequity exists in maternal mortality rates and coverage of maternal health care both within and between low-income regions, with the sole exception of Sri Lanka, where there is virtually no difference between wealth groups (see the third paper in this series). With respect to the supply of maternal health services, underinvestment means insufficient numbers of adequately trained health professionals are available, reaching less than 10% of requirements in some areas,[2] and underequipped health facilities. To scale-up maternal health interventions and reduce the global burden of maternal ill health, a concerted effort is needed to reach out to those who are currently excluded from such care.

In this paper, we begin by expounding the case for investment in maternal health. We then consider how financial resources can be channelled to maternal health within countries, examining the limitations and successes of conventional financing mechanisms as well as some alternative methods in providing quality care and ensuring access to the poor. Although much debate has taken place about financing of health services in general, with the exception of one study,[3] the implications of different financing mechanisms for maternal health have not been discussed so far. We end by summarising the additional financial resources needed to scale up effective maternal health services, and discussing the mechanisms for making these resources available. Key messages are shown in panel 1.

Search strategy and selection criteria

We searched PubMed, Popline, Embase, IBSS, Paho, and Lilacs from 1990 to 31 July, 2004. The search terms used were: (Mother* OR Matern* OR Newborn OR Neonat* OR reproduct* OR obstetric) AND (fee OR fees OR charge OR charges OR insurance OR insured OR financ* OR reform) AND (Africa OR Asia OR Latin OR Caribbean OR Soviet OR Eastern Europe). In view of the numerous reforms that took place in the 1980s, we did not include studies published before 1990. The searches were limited to English language publications dealing with human beings. We also reviewed the websites of major international organisations working in reproductive health (The World Bank, WHO, Partnerships for Health Reform, International Planned Parenthood Federation, Population Council, Measure, Frontiers, UN Population Fund, UN Children's Fund, and the Pan-American Health Organization). Lists of all identified references were reviewed for additional relevant studies. All relevant references were extracted to an Endnote file.

Why invest in maternal health?

The case for investment in maternal health is compelling. In addition to the proven effectiveness and cost-effectiveness of many maternal health care interventions,[4–6] there are numerous benefits in addition to the maternal lives saved.[3] Most maternal interventions also directly benefit newborn babies in terms of reduced mortality and morbidity.[7] A maternal life saved also benefits older children. Children whose mothers die have been suggested to be at three to ten times greater risk of death than those with living parents.[2] Investment in maternal health also

Panel 1: **Key messages**

- The case for investment in maternal health care is strong
- Households need financial protection to encourage them to seek care, especially poor people
- User fees hurt the poorest people
- Removal of fees and funding of maternal services through general government revenue is a promising way to increase coverage among the poorest people as long as certain conditions are met
- Insurance schemes struggle to reach the poorest people
- Targeted approaches have been effective, but more evidence is needed from low-income countries on cost and effectiveness
- Countries need to select financing strategies adapted to their local context, estimate domestic resource requirements to implement strategies, lobby for additional funds, show that funds are used effectively

has valuable equity benefits, since differences in maternal mortality mirror the huge discrepancies between rich and poor people both within and between countries.[8,9] Poor people are especially vulnerable during pregnancy; they have less access to cash and live further away from health facilities, limiting the health care options available to them. Addressing maternal health therefore contributes to global and national efforts to alleviate poverty.[10] Strategies to improve safe motherhood will also achieve wider health service improvement.[11] Indeed, maternal health indicators have been used to trace the performance of health systems[12,13] in terms of access by poor people, gender equity, and institutional efficiency.[10] As a result, investment in maternal health services is likely to have positive effects for health service delivery in general.

Channelling financial resources to maternal health

The provision of effective maternal health services requires money for staff, drugs, medical supplies, and food.[14] These costs will differ between facility and home delivery. Seeking care at a health facility has additional financial implications for the household in terms of travel costs and patients' and their companions' time, which are subject to seasonal variation.[15] Here, on the basis of a systematic review of published and unpublished studies of financing and maternal health (see search strategy), we present evidence for how these costs are currently financed, and how to offer greater financial protection to poor people.

Most countries have at least three mechanisms for financing maternal health services. Usually, there is a principal financing mechanism, such as tax revenue, or social health insurance, combined with user charges (both formal and informal), together with supplementary community financing for specific services and components of the health system. In most low-income countries, the funding for maternal health care is shared between government (through tax revenue) and households.

User fees

User fees have almost always been shown to hurt poor people and prevent them from gaining access to needed care: maternal health is no exception. Although in principle user fees can be used to ensure a proper use of the referral system, improve quality of care, and reduce frivolous demand for care,[16] they are problematic for services such as maternal health, for which demand is inadequate. Where fees are elicited for maternal health services, households pay a substantial proportion of the cost of provision of facility-based services.[3] Even when formal charges are not levied, unofficial and additional costs might be incurred. The situation is exacerbated for deliveries—the single most costly event during pregnancy—and the postpartum period, and more so for complicated deliveries which usually cost households between three and ten times more than normal deliveries. The cost of complicated deliveries is often catastrophic, defined as being in excess of 10% of yearly household income.[17] Table 1[14,18–21] shows delivery costs as a proportion of yearly gross domestic product per head; this measure is used as a proxy for individual income, of which delivery-care costs represent a substantial proportion. Several studies have reported that women have to purchase supplies such as bleach to sterilise materials, bed sheets, gauze, gloves, and sanitary pads when admitted to a health facility for delivery.[18,19] The process of obtaining relevant supplies and drugs can delay access to timely care.[22] Food is often bought in by relatives for the patient,[14]

	Year	Yearly gross domestic product per head in 2006 (US$)	Normal delivery in hospital		Caesarean section or complications	
			Cost (US$)	% of gross domestic product per head	Cost (US$)	% of gross domestic product per head
Benin[19]	2002	530	15–36	3–7%	60–269	11–51%
Ghana[19]	2002	380	19–23	5–6%	59–132	16–35%
Tanzania[18]	1997–98	330	9*	3%	10	3%
Bangladesh (rural)[21]	2000–01	278	31*	11%	250–385	90–138%
Bangladesh (urban)[20]	1995	278	32*	12%	118	42%
Nepal[14]	2004	260	67*	26%	132	51%

Costs are calculated in US$ according to 2006 prices. *Includes transport costs.

Table 1: **Household costs of delivery care by country**