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Demand-side financing for maternal health care: the current state of knowledge on design and impact

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Introduction

This issues brief—developed by the Health Policy and Health Finance Knowledge Hub at the Nossal Institute for Global Health and the Centre for International Health at the Burnet Institute—synthesises the current state of knowledge on demand-side financing (DSF) for maternal health care.

Why is demand-side financing important for maternal health care?

Evidence suggests that poor women in developing countries often do not have adequate access to maternal health services. Both supply-side constraints and demand-side barriers are responsible for the low use of these services. It is known that poorer households face numerous financial and non-financial barriers that prevent their access to services, even where services are nominally free. Increasingly, policy makers in many low-income countries are considering the use of DSF systems, as an alternate mechanism to accelerate progress towards the achievement of MDG 5—the reduction of maternal mortality. What, then, is the current state of knowledge on DSF for maternal health care and what additional evidence is needed?

What is demand-side financing?

Demand-side financing includes a range of mechanisms that provide direct subsidies to the poor for access to specified health services. Generally, the subsidies are targeted at users rather than the service providers. The aim is both to protect patients from unaffordable costs of care and to increase the purchasing power of consumers in relation to health providers. The use of

KEY MESSAGES

- DSF systems use different approaches to target different population groups, and can increase the use of maternal health services.
- DSF program design and implementation issues are critical determinants of success.
- Globally, DSF programs are growing in number and diversity, while the evidence base is still being developed.
- Strategically, policy makers may choose to initiate DSF systems as pilot projects, with an intention to scale up if they prove to be successful.
- A more complete evidence base is needed by governments and development partners to identify the conditions under which DSF mechanisms improve access to quality maternal health services without financial burden.

DSF mechanisms is intended: (1) to increase the overall use of specific services, (2) to increase equitable access to care by vulnerable groups and (3) to help improve the quality of services provided. Most importantly, the use of DSF mechanisms has the potential to achieve universal coverage of particular forms of care, especially deliveries by a skilled birth attendant in a health facility.

What is the current state of knowledge?

There is an extensive literature on DSF for health care in developing countries, covering the implementation of social health insurance, community-based health

insurance (CBHI), health equity funds, voucher schemes, conditional cash transfers (CCT) and other mechanisms. The quality and nature of the evidence in this literature varies. From earlier attempts to systematically review this literature, it appears the use of rigorous research methods, including controlled trials, is limited.

Demand-side subsidies are either consumer-led or provider-led (PL). Consumer-led subsidies, like CCTs, incentives or targeted vouchers, are transferred directly to the service user; the evidence suggests some success in targeting vulnerable groups and raising utilisation but little impact on improving quality of services. Provider-led subsidies have greater potential to affect the quality of services.

DSF mechanisms for maternal care may target different points in the cycle of pregnancy, childbirth and post-partum care—each with varying potential for mortality reduction. Published evidence shows that vouchers, CCT and other DSF systems may use different mechanisms to target certain women, such as providing universal coverage in a defined geographic area or through means-testing to identified poor or vulnerable households.

An increasingly common DSF initiative is to issue vouchers to pregnant women for free or discounted access to services. The literature commonly, but mistakenly, refers to DSF and vouchers synonymously. Targeted vouchers are one DSF system with clear potential to improve equitable maternal health care utilisation; they can be used to target poor women, reduce financial barriers to access and encourage the use of maternal health services.

While evidence on the impact of CCTs is limited, it appears they may not always overcome barriers to access. However, there is preliminary evidence that maternal health voucher schemes are effective in increasing the use of maternal health services. Incentive payments in Indonesia, China and Nepal have been accompanied by significant increases in utilisation of facility-based childbirth.

Considerable variation is found across both CCT and voucher schemes in terms of program design, selection criteria and involvement of accredited providers. However, evaluation of some schemes has demonstrated problems such as a decline in quality of care or failure to increase utilisation by the very poor.

Among PL DSF schemes, the most common are community-based health insurance, health equity funds and provider incentive programs. There appears to be little published on the degree to which these schemes directly address maternal health, though these schemes are sometimes used to good effect in combination with targeted vouchers for maternal care and with provider subsidies. The evidence also suggests that CBHI schemes may have limited coverage and do not necessarily benefit the poor.

What makes a maternal health voucher scheme successful?

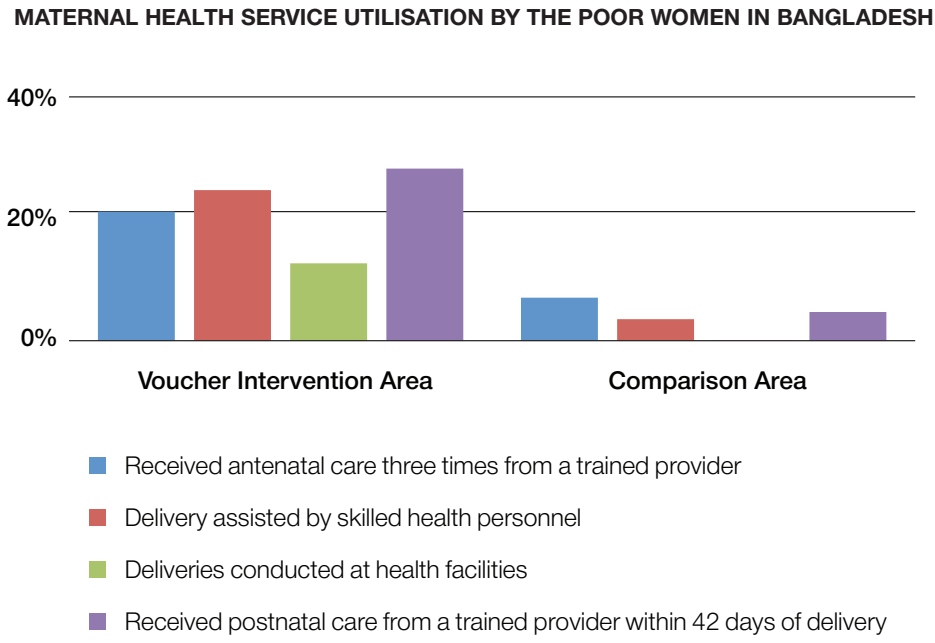
Findings from studies in Bangladesh, Cambodia and other countries indicate that program design and implementation issues—such as selection criteria for eligible women and readiness of health systems to provide services—are critical determinants of success. There is evidence that well designed and implemented voucher programs have significant advantages but less evidence on cost-

The contribution of DSF to key policy objectives

Improving equity - by removing financial barriers to access to services for the poor (linking demand to supply)

Expanding coverage - Improving utilisation of social sector goods or services (changing demand-side behaviour)

Increasing the scope and quality of service - Promoting competition and choice to improve quality (changing provider behaviour)



effectiveness and links to mortality reduction. It is argued that DSF systems help to reduce patient delays, particularly in deciding to seek care and in receiving maternal health care, though there is not sufficient evidence yet to support this claim.

Possible limitations on the evidence and the need for further research

The evidence base on DSF systems is varied. Much of the evidence is descriptive or based on less rigorous qualitative evaluation techniques. This initial review indicates there are few rigorous and robust controlled trials or randomised controlled trials. Therefore there may be limitations in the confidence that can be placed in the findings of such studies.

From a review of the literature, it is clear there is considerable variation across different DSF systems. Both the design components and the context in which these systems were implemented varied. The timeliness and appropriateness of DSF systems within the structure and governance of the wider health system are factors determining their success. A stronger evidence base could be constructed particularly by studies comparing DSF scheme across time. While different studies evaluated DSF systems at a particular time (cross-sectional studies), in only a few cases were DSF systems evaluated over longer periods (longitudinal studies).

Although the literature on DSF is extensive, hard evidence on the impact of DSF on maternal health is limited. Therefore, the piloting of DSF schemes is one way to gather the necessary evidence on implementation and design. Strategically, policy makers may choose to start a voucher or other DSF scheme on a small scale with the aim of scaling up if schemes prove to be successful. Further operational research and a stronger evidence base are needed by policy makers and donor partners to verify the impact of DSF scheme design and implementation and the factors determining impact.

References and further reading

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