MLI

Ministerial Leadership Initiative

ASPEN GLOBAL HEALTH AND DEVELOPMENT

REDUCING FINANCIAL BARRIERS TO REPRODUCTIVE HEALTH CARE:

Experiences with Free Care and Health Insurance

Ministerial Leadership Initiative for Global Health

ISSUE BRIEF

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MLI works to strengthen the leadership capacity of ministries of health in Ethiopia, Mali, Nepal, Senegal, and Sierra Leone in order to advance policy in three interrelated areas: health financing for equity, donor harmonization in health, and reproductive health. MLI is a program of Aspen Global Health and Development, a legacy program of Realizing Rights: The Ethical Globalization Initiative, in partnership with Results for Development Institute and the Council of Women World Leaders. MLI collaborates with the World Health Organization (WHO) to disseminate and foster dialogue about the WHO Report, Women and Health: Today's Evidence, Tomorrow's Agenda. MLI is funded by the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation.

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LEADERSHIP FOR AN EQUITABLE WORLD

RESULTS FOR DEVELOPMENT INSTITUTE

THE ASPEN INSTITUTE COUNCIL OF WOMEN WORLD LEADERS

1 INTRODUCTION AND PROBLEM STATEMENT

As many countries struggle to meet the United Nations Millennium Development Goals (MDGs), there is a growing trend worldwide to implement strategies designed to reduce financial barriers to health care, especially for certain priority services and groups[1]. With developing country health systems focusing heavily on reducing child mortality and improving maternal health (MDGs 4 and 5), there is inevitable tension deciding between financing strategies that will bring fast improvements in specific indicator areas (such as reproductive health), and those that target the entire health care system and may be more sustainable in the long term. While a variety of tools is being employed to reduce the financial burden on households for health care, two of the most prominent are the expansion of free services policies and the expansion of health insurance. This issue brief aims to examine recent experience with such initiatives and their relative strengths and weaknesses. It will attempt to draw lessons from the literature about how and when to use such policy tools, alone or in conjunction with other tools, to reduce financial barriers to reproductive health (RH) care and build a sustainable national health financing strategy.

The Ministerial Leadership Initiative for Global Health (MLI)[2], funded by the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation, supports ministries tackling these challenging issues around equitable financing and reproductive health[3]. MLI's demand-driven support in three of the five MLI countries (Mali, Senegal, and Sierra Leone) directly addresses the complex dynamics of needing to boost progress in RH indicators, implementing free care policies, and launching health insurance systems, and touches on these financing mechanisms in the other two (Ethiopia and Nepal). A central objective of this issue brief is therefore to establish a context for exchange and ongoing cross-learning between MLI countries as these financing strategies evolve and progress.

After describing the context for financing strategies to improve reproductive health outcomes overall and specifically in MLI countries, this issue brief outlines the main features of various financing tools used in this context. It then delves more in-depth into lessons learned through experiences to date at different phases of implementation, drawing from the experiences of MLI countries, as well as Ghana and Rwanda.

[1]High levels of out-of-pocket spending, the most inequitable and inefficient way to finance health, persist in many countries, and constitute a significant financial barrier to care seeking.

[2]MLI is a program of Aspen Global Health and Development, a legacy program of Realizing Rights: The Ethical Globalization Initiative. MLI partners are the Results for Development Institute and the Council of Women World Leaders. MLI also works in collaboration with the World Health Organization to disseminate and foster dialogue about the WHO Report, *Women and Health: Today's Evidence, Tomorrow's Agenda*.

[3]Within the context of MLI, the term RH is used broadly and encompasses maternal and reproductive health issues, including family planning. However, this paper focuses primarily on maternity care, as financial barriers to maternity care are particularly problematic (Borghi et al 2006.) Family planning is a key part of RH care and birth spacing and reduced fertility contributes significantly to reductions in maternal mortality and morbidity. While the cost of family planning commodities are not usually a barrier to seeking family planning care, it is important to note that methods that require medical visits (usually long-lasting methods) and related counseling visits often have associated fees.

2 CONTEXT

There are a growing number of countries implementing some form of free care policy[4], including Benin, Burkina Faso, Kenya, Liberia, Mali, Nepal, Niger, Senegal, Sierra Leone, Sudan, Uganda, and Zambia. To date, rigorous evaluation of implementation experience and the policy's impact on health indicators and on the health system has been inadequate. There is evidence from a number of countries that instituting free care policies improved utilization of target services and had a positive impact on the rate of assisted deliveries and/or Cesarian sections, although weak monitoring and poor health information systems render these findings less than conclusive (Immpact 2007, UNICEF 2009). At the same time, an increasing number of countries are undertaking reforms and pilot activities to bolster health insurance – most visibly Ghana and Rwanda, but also Benin, Burkina Faso, India, Ethiopia, Mali, Niger and Nigeria, just to name a few. As a strategy to improve financial access, boost the utilization of modern health care services, and bolster overall health care financing, these countries are turning to health insurance, often after many years of supply-side investments. There is a growing evidence base that insured populations are significantly more likely than the uninsured to use key health services (Chankova 2008). Overall, evidence is strong that removing fees at the point of service improves the rate of utilization of health care services (McIntyre 2007).

However, in many countries there is fragmentation within health care financing strategies, rendering them less effective than they could otherwise be. Where both free care and insurance initiatives are underway, they are often led or managed by different parts within the same ministry, or in other cases, by different ministries. There is little articulation of how these two financing strategies relate and interact, and the two are run in parallel with little thought to their evolution over time – sometimes even competing for scarce resources and political will, rather than working in a mutually reinforcing way.

FIGURE 2.1

A FINANCING STRATEGY MEANS:

A financing strategy identifies specific sources to reliably and sustainably pay for the goods and services required to provide the health service(s) in question.

A FINANCING STRATEGY SHOULD INCLUDE:

1. Source(s) of funding

2. Mechanisms for paying providers or paying for inputs to be given to providers

3. Adequate and sustainable funding compared to the likely costs of the inputs and the quantity of them likely to be used

4. Possible intermediation between the source and the providers (including insurance agencies, voucher schemes, supply-side subsidy arrangements)

5. Targeting mechanism (including 'free care for all' that targets everyone)

6. Administrative arrangements to implement the strategy (including startup, transitions from previous strategies, and operating the chosen strategy)

The choices made each step of the way have implications for the quality of the services used, efficiency in the use of resources, equity in the use of the services and in who pays for them, the ratio of services used to services needed (note that this ratio can be greater than 1.0, as in the case of Cesarean sections), and the opportunity cost of the financing of the specific service(s) versus other use of the financing.

[4]In many cases, countries have been eliminating user fees that were instituted in order to improve performance and increase health sector resources. However, research showed that fees were an obstacle to health care seeking and could be deadly in the case of obstetric emergencies.

REPRODUCTIVE HEALTH FINANCING CONTEXT WITHIN MLI COUNTRIES

As reflected by the range of maternal mortality ratios shown in Figure 2.3, the overall reproductive health of women in MLI countries varies widely. What these countries have in common is a high-level political commitment to reduce financial barriers to the utilization of modern health services, though they have different financing strategies to achieve better outcomes toward meeting MDG targets. The table below provides an overview of RH indicators in MLI countries.

FIGURE 2.2

INDICATOR	ETHIOPIA	MALI	NEPAL	SENEGAL	SIERRA LEONE
Percentage of women of reproductive age (15-49)	42.7 (2005 DHS)	42.3 (2006 DHS)	49.6 (2006 DHS)	46.3 (2008 DHS)	37 (2008 DHS)
Total fertility rate	5.4 (2005 DHS)	6.8 (2006 DHS)	3.1 (2006 DHS)	4.9 (2008 DHS)	5.1 (2008 DHS)
Population growth rate	2.5 (2005-1010 UNDP)	3.6 (2009 Gen. Pop. & Housing Census)	2 (2005-1010 UNDP)	2.6 (2002-08, WB, Dev. Econ. LDB)	2.54 (2008 WDI)
Maternal mortality ratio (per 100,000)	673 (2005 DHS)	464 (2006 DHS)	281 (2006 DHS)	401 (2005 DHS)	857 (2008 DHS)
Percentage of deliveries assisted by qualified personnel	5.7 (2005 DHS)	49 (2006 DHS)	18.7 (SBA 2006 DHS)	52 (WHOSIS 2006)	42.4 (2008 DHS)
Percentage of women of reproductive age using modern FP methods	14.7 (met need, 2005 DHS)	6.4 (2006 DHS)	48 (married women only, 2006 DHS)	7.6 (married and unmarried, DHS 2005)	8.2 (married women only, 2008 DHS)
Percentage of unmet family planning need	33.8 (2005 DHS)	29 (married women only, 2006 DHS)	24.6 (married women only, 2006 DHS)	31.6 (married women only, DHS 2005)	27.6 (married women, 2008 DHS)

In terms of health care financing strategies, **Ethiopia** is moving away from a largely unoperationalized free care policy toward social and community-based health insurance, which may include RH exemptions.

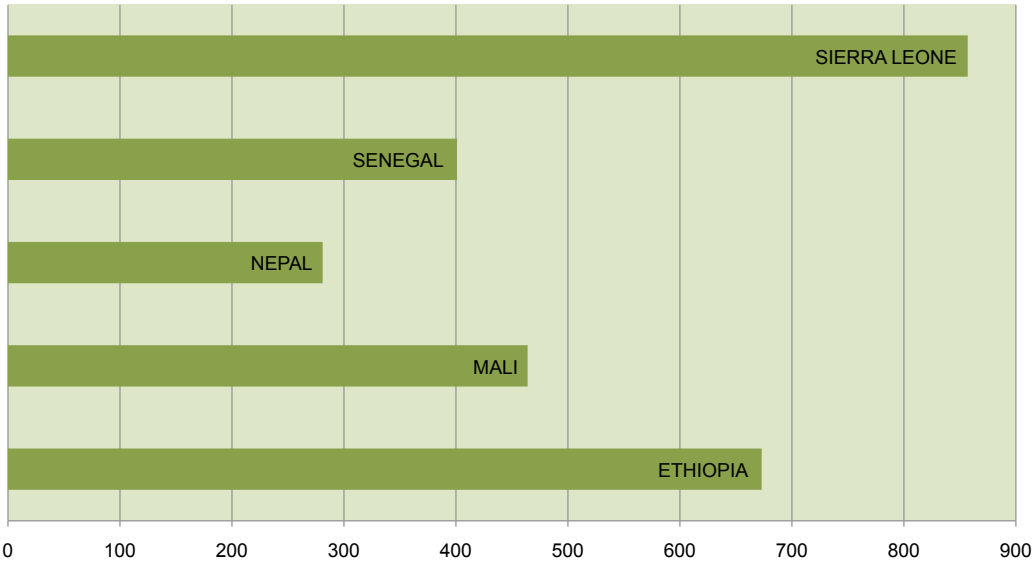
Sierra Leone, still recovering from its decade-long civil war, has just launched a free care policy for all pregnant women, lactating mothers (up to 12 months post delivery), and children under five. The plan is designed to increase access for 230,000 women and 950,000 children and, though estimates vary, will cost roughly $91 million in 2010 alone (Government of Sierra Leone, 2009).

Nepal announced a policy of free essential healthcare for its population in 2008. The maternal health components of the free care program build from Nepal's Safe Motherhood Programme that provided conditional cash transfers to women delivering in a modern health facility.

Senegal launched a free delivery care policy in 2005 that was extended to cover all regions except Dakar in 2006, providing free deliveries at all health posts and free C-sections to all women at district and regional hospitals. Senegal has also developed a national strategy to scale up universal coverage for health risk as well as an initiative to articulate an overarching financing framework for multiple financing mechanisms, including insurance and equity funds to cover specific exemptions and populations. Funding and implementation of the strategy have lagged.

Mali implemented a free C-section initiative throughout the country in 2005[5]. Since the launch of this initiative, the C-section rate in Mali has more than doubled, and the government's financing of the initiative has more than tripled (Fournier 2009). Political will behind the policy remains high and a rigorous evaluation is underway. Mali has also embarked on a mission to make universal health insurance a reality, creating a national health insurance scheme, an equity fund for the poor, and a strategy to scale up community-based health insurance nationwide with significant government co-financing. By 2015, Mali aims to have covered 45% of its population through a mix of social health insurance, community-based health insurance, and the equity fund for the indigent (Government of Mali 2010).

FIGURE 2.3 | MATERNAL MORTALITY RATIO IN COUNTRIES



Source: Latest Available Demographic Health Surveys

[5]The policy covers all institutional costs of C-sections performed in public sector facilities (CSREFs and hospitals), which are reimbursed up to $60 per case. In addition, C-sections kits were also distributed to public sector facilities performing the procedure, although the replacement of kits has posed problems – insufficient quantities and incomplete, especially in products needed for complicated cases.

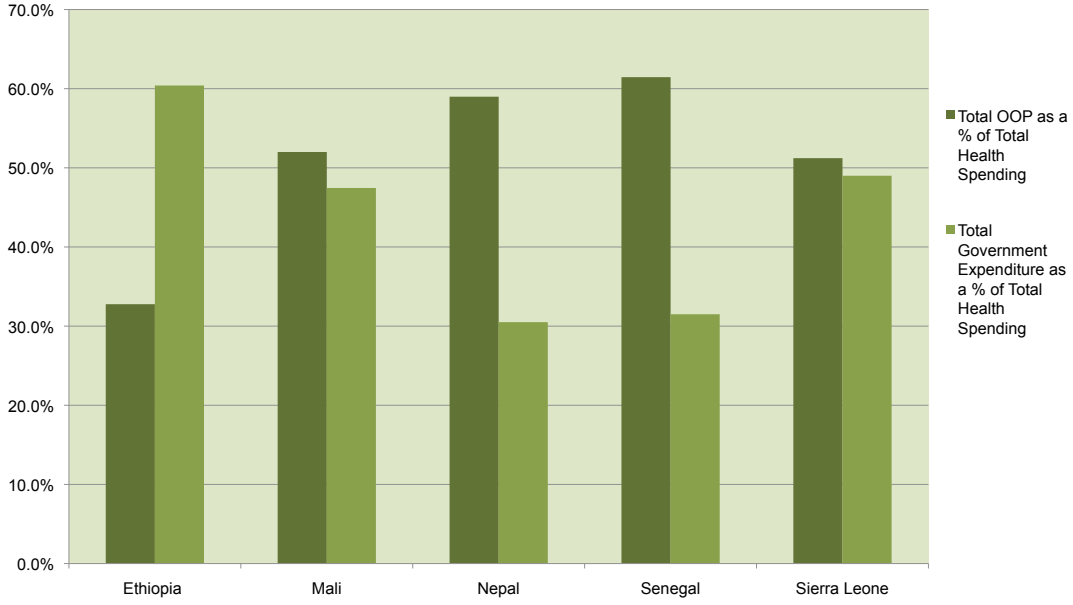
3 OVERVIEW OF COMMON APPROACHES TO OVERCOMING FINANCIAL OBSTACLES

The purpose of this section is to present an overview of financing tools that governments may use to achieve specific and overall health objectives. It is important to keep in mind that in reducing financial barriers *to* care, we do not mean reducing overall financing *of* the health care system. To achieve a sustainable health care financing strategy, governments must take into account how the financing strategies they select work together, assessing whether they overlap, interact, replace one another over time, or even compete.

One of the greatest barriers to *accessing* healthcare is out-of-pocket expenditure, which affects patients in developing countries across the world. In sub-Saharan Africa and South Asia, out-of-pocket spending comprises 35.4% and 65.7% of health expenditure, respectively[6]. Consequently, low-income groups face a disproportionate risk of catastrophic loss of savings or other property from a sentinel health event or even more routine health expenditures. Figure 3.1 below depicts the relative share of household (out-of-pocket) and government health spending as a percentage of total health spending in the five MLI countries.

Figure 3.2 outlines a variety of financing tools that aim to minimize the excessive burden of out-of-pocket expenditure on health. Some tools, such as vouchers, cash transfers or exemptions, may be most appropriate for a discrete service (like free C-section), specific population group, or limited geographic scope or period of time. Others, like insurance, may work better for more integrated, comprehensive coverage (such as maternal and well baby care). Ultimately, the potential of any of these mechanisms to have its desired impact – reduction of maternal mortality, for example – depends largely on effective implementation. One also must be certain that financial barriers are a major factor related to low service utilization, as opposed to other issues related to cultural or geographic barriers or the quality of services provided.

FIGURE 3.1 | HEALTH SPENDING IN MLI COUNTRIES



WHO 2006

[6]World Development Indicators, 2010.

FIGURE 3.2 | OVERVIEW OF APPROACHES TO OVERCOME FINANCIAL BARRIERS TO REPRODUCTIVE HEALTH

Tool	Financing mechanism	Target	Key management features	Supply/ demand-side	Potential pros and cons	MLI Country examples
Universal free care	Government provides subsidies to public providers for staff and supplies	Entire population or particular age/ population group (<5s, > 60s, pregnant women)	Fund management may be centralized or decentralized	S	Reduced HH financial burden Revenues tend to decline in HC Informal payments tend to rise Quality may go down as volume increases unless preparation adequate Associated costs usually not covered (transport) Universal, does not target neediest	Nepal Sierra Leone
Exemptions from user fees	Case payments to providers for services rendered to exempted populations or for exempted services	Set of services or particular age/population group (<5s, > 60s, pregnant women)	Fund management may be centralized or decentralized	D	Reduced HH financial burden Revenues tend to decline in HC Informal payments tend to rise Quality may go down as volume increases unless preparation adequate Associated costs usually not covered (transport)	Mali Senegal
Health Equity fund	Fund with state and local contributions reimburses for agreed upon number of persons per locality	The poor	Central design Eligibility and management handled locally	D	Determining eligibility may be difficult Difficult to predict costs Associated costs not covered (transport) Per person health costs may be higher than average for this population segment, which tends to be relatively sicker	Mali
Vouchers	Voucher agency provides case payment to providers for vouchers received	Specific services (high priority and/or underutilized) or target population group	Agency to process and verify claims Voucher distributors	D	Empowers consumer choice of provider Encourages utilization Administration of voucher scheme may be heavy, costly Requires fixed package and easily identifiable target group	Ethiopia
Insurance	Third party purchaser contracts with providers on behalf of insured population and reimburses based on outputs	Entire population, or segments, such as formal sector or informal sector	Usually mixed funding (public and private) Health insurance agency/fund to serve as payer Systems for formal and informal sector schemes may differ	D	Complex to set up Risk of moral hazard Reduced HH financial burden Can improve equity, efficiency, quality	Mali Senegal Ethiopia

Adapted from Soors 2008

4 LESSONS ON SELECTING AND IMPLEMENTING DIFFERENT FINANCING APPROACHES

Limited resources and high operational complexity argue for creating coordinated, efficient, and sustainable health financing systems that maximize coverage while targeting subsidies to the neediest and the highest priority services. This section draws on literature and experiences from MLI countries and beyond to identify lessons and gaps in our knowledge about how best to finance reproductive health.

AT THE LAUNCH

Initiatives to launch or expand free care policies and insurance have largely begun in the political realm in many countries. In **Rwanda**, the impetus to expand health insurance nationally came directly from the president. In **Ghana**, a presidential campaign pledge to abolish user fees led to the establishment of the NHIS. **Sierra Leone's** free care initiative was announced by the president and set to begin on the anniversary of the date the country gained independence from Great Britain. **Nepal's** free care policy was enshrined in the interim Constitution established after the abdication of the monarchy in 2008. While such high-level political will is essential for advancing big reforms such as these, it can also result in their being launched too quickly with inadequate technical preparation and questionable sustainability. Once these systems are in place, it becomes more difficult to reform them or to fit them within a system-wide health financing strategy.

Another critical element to a successful launch is effective communication of the policy to stakeholders within the health system (like health personnel), opinion leaders (whether elected or religious), and to the target population. Such reforms tend to be complex; ensuring that objectives and processes are understood helps generate interest and minimize problems during implementation. In **Mali**, inadequate communication of the free C-section initiative had consequences that ultimately reduced its potential effectiveness. In 2002, in an effort to mitigate financial barriers to emergency obstetric care, Mali put in place a referral system for obstetric emergencies. One component of this system was community emergency transport funds, to which local government, local health services, and community health associations contributed. The fund was used to reimburse health providers for services rendered to referred women. When Mali instituted the free C-section initiative in 2005, there was confusion about what was covered. At the community level, it was wrongly assumed that transport costs were included. Therefore community health committees and local government officials no longer wanted to contribute to the emergency transport funds, which soon fell apart. In fact, while ambulances are provided at second-level health facilities, the free C-section initiative intends that maintenance and fuel costs are shared among local government, local health services, and local community health associations. This misunderstanding means that transportation costs remain a barrier to the free C-section program today, despite the fact that a system for covering these costs existed at the onset of the program and could have been easily adapted.

DURING THE IMPLEMENTATION PHASE

The success of any policy initiative depends on its effective implementation. There are a number of common implementation difficulties that countries face when tackling free care or health insurance initiatives.

Senegal rolled out a Free Delivery and Cesarean Policy (FDCP) in 2005 in five predominantly poor regions with the goal of increasing the number of deliveries at health facilities and improving its maternal health indicators[7]. The FDCP was extended to all regional hospitals (except those in Dakar) a year later. An evaluation conducted after the policy had already been extended found that the policy did reduce the cost of RH care significantly for most users. Utilization rates for normal deliveries and Cesarean sections increased significantly (from 40 to 44%, and 4.2 to 5.6% respectively during 2004-5). However, the evaluation also enumerated numerous obstacles to implementation and resource allocation (Immpact 2005 and Witter 2008). In a 2009 "road map" to expedite its strategy to scale up universal coverage for health risk, Senegal presented a situation analysis of the implementation problems plaguing its free care initiatives (targeting deliveries and care for persons over 60 years of age). This assessment provides a concrete summary of the implementation challenges that many financing strategies face, depicted in Figure 4.1.

FIGURE 4.1 | IMPLEMENTATION CHALLENGES IN SENEGAL'S FREE CARE INITIATIVES

LOGISTICAL PROBLEMS

- Ensuring that estimations made at central level match health center needs
- Management of supplies at health facility level

ORGANIZATIONAL PROBLEMS

- Heavy administrative procedures, slow processing time
- Rigid accounting procedures, problems reimbursing money to health facilities without requisite legal status

FINANCING PROBLEMS AT CENTRAL LEVEL

- Inadequate auditing of services provided to beneficiaries
- Utilization exceeding financing available

FINANCIAL PROBLEMS IN HEALTH FACILITIES

- Non-financial contributions through program inadequate to meet demand, especially following volume increase
- Health staff receiving shrinking remuneration due to actual costs incurred by facilities not being reflected in reimbursement rates
- Prices of other services being raised to compensate for revenue loss from free service program
- Drug stock-outs or higher prices on drugs due to revenue shortages

Stratégie national d'extension de la couverture du risque maladie: Feuille de route, CAFSP, Ministère de la Santé du Sénégal, 2009.

[7]The FDCP covers normal deliveries at health posts and centers, and Cesareans at district and regional hospitals for all women. The government implemented this policy through the provision of subsidized kits with basic supplies for normal deliveries, which were intended to replace out-of-pocket payments. The regional hospitals performing Cesareans received a remuneration of 55,000 FCFA per case, with some paid in advance according to estimated figures and the rest to be reimbursed to the hospitals.

Implementation of financing initiatives requires support and supervision, and this reality should be considered before putting multiple and complex financing mechanisms in place. If there are funding problems at the national level, the regional, district and facility levels need to know to be able to make informed decisions. Lower levels needs to be informed about how long funds are expected to last, and how the various financing mechanisms they encounter are intended to work together. The national level needs to be informed about how the mechanism is working and whether it is achieving its intended objectives. The Government of **Sierra Leone** has created a number of strategies to support the implementation of their new free care policy, including working groups to address specific challenges, such as what incentives might help retain healthcare providers given the increase in patient load due to free care.

As the **Senegal** experience demonstrates, resource allocation is key to successful implementation and sustainability. Free care policies and exemptions are only respected by health care providers if their facility is regularly and adequately compensated for this "lost" revenue. In **Ethiopia**, services exempt from fees are set at the regional level, often including deliveries, antenatal and postnatal care. However, government budget allocations are rarely made there for fee exemptions, which are primarily financed through donor vertical program funding, and as such, their financial sustainability is not assured. On the eve of implementation of its free care initiative, 230,000 pregnant women and 950,000 children in Sierra Leone were eligible for free care, pushing the initial cost of the policy to $91 million in 2010. This is over five times of total public expenditure on health in 2007 (WDI 2010). While the Government of **Sierra Leone** is poised to commit $12.5 million to the program, and its development partners have promised approximately $71 million to help eliminate user fees, a gap of over $20 million remains for the first year (Government of Sierra Leone 2009 and Thomas 2010).

We must keep in mind that in implementing any of these financing mechanisms, there are trade-offs between the ability to target services or populations precisely, the administrative burden of implementation, and their financial sustainability over time.

CONTINUING EVALUATION

Ensuring timely and rigorous evaluation is challenging in any health reform, but especially in the design and implementation of complex financing strategies.

Rwanda's pursuit of universal health coverage stands out as an example not only because of its success, but also because it has been so well evaluated and documented. Because the policy began as a pilot initiative in Rwanda, ample and rigorous monitoring and evaluation was built in not only to the pilot but into the system itself. Rwanda has capitalized upon this institutionalized mechanism to take stock at critical junctures and make adjustments where necessary. The process became ingrained in the system, and even today at population coverage rates of 80-85%, the system is continuously adapted to ensure continued success and sustainability as changes occur. Now that Rwanda's health financing strategy has married health insurance with performance-based financing, it is ever more difficult to distinguish the impact of one from the other, but the two work together in a concerted way to achieve the impressive results Rwanda is seeing today.

Mali's free C-section program is currently being evaluated[8], with funding from USAID. The evaluation focuses not only on impact on key maternal health indicators, but also on implementation issues and key remaining barriers to access. MLI is supporting the Ministry of Health to maximize its use of the results of the evaluation to inform decisions and practices regarding the C-section program, but also to define appropriate future interventions or programmatic changes to reduce maternal mortality.

EXTENSION AND EVOLUTION

There is very little documented experience with successful national extension of financing policies[9], and even less in the dovetailing of financing strategies. After all, finding a way to systematically and sustainably finance health care is a complex affair. Ghana's experience with its delivery exemption policy and subsequent national health insurance provides insight into some of the challenges to combining and extending such financing strategies, and ultimately transitioning from one to another.

"THE EXEMPTION WAS A POLITICIAN'S WHIM, TO PLEASE THE PEOPLE, WITH NO THOUGHT TO SUSTAINABILITY."

– KEY INFORMANT, DISTRICT LEVEL

Ghana introduced an exemption policy for delivery fees in 2003 covering all facility costs for intrapartum care in both public and private facilities. Initial funding for the exemption policy came from a debt relief fund under the Highly Indebted Poor Countries Initiative (HIPC). Launched in the four poorest regions of the country expected to have the greatest need, the exemption policy involved setting reimbursement rates nationally for different types of delivery (normal, assisted, Cesarian) and in different settings (public or private). Reimbursements were channeled through district assemblies, who retained discretion over how and to whom reimbursements were made. Although there was substantial variation in the policy's application, it was extended to the remaining six regions in 2005 before any assessments or adjustments of the policy (Grepin 2009). Meanwhile, districts that had received funds in early 2004 had no idea when the next tranche of funding would appear, and began to run out of money to reimburse providers toward the end of the year (Adjei 2007). Often already operating in debt, districts received a second tranche of funding in February 2005, this time from the Ghana Health Service, but it was smaller, and ran out in most places by mid-year. Facilities began charging for deliveries again.

"IT IS DIFFICULT TO CHARGE NOW AS PEOPLE WILL THINK YOU ARE CHEATING THEM. BUT WHAT DO I DO WHEN I HAVE NO DRUGS LEFT?"

– KEY INFORMANT, FACILITY LEVEL

An evaluation to measure the policy's effectiveness was launched, but only after its extension and when funding was already uncertain. Political and financial support of the policy had begun to falter, coinciding with the building momentum of Ghana's national health insurance scheme (NHIS). Advocates of the exemption policy argued that the NHIS uptake would be gradual and that exemptions were necessary in the interim to protect women and their households. But it became increasingly difficult to argue for budget support for exemptions when hopes and expectations were high that the NHIS would cover the costs of deliveries (Adjei 2007). Despite significant increases in supervised deliveries and institutional births, as well as reductions in delivery costs as a result of the exemption policy, transition planning to cover deliveries through NHIS was poor (Grepin 2009). Women once covered by the exemption policy went back to paying for deliveries as NHIS coverage progressed. Finally, in May 2008, the president announced a policy of free medical care for pregnant women through the NHIS, constituting a formal policy shift, with the objectives of the delivery exemption fully subsumed by NHIS coverage.

[8]The evaluation relies on a combination of quantitative and qualitative data collection, and prospective and retrospective analyses to answer the research questions.
[9]With the notable exception of Rwanda's scale-up of health insurance

Mali is likely to confront a similar challenge as health insurance coverage evolves. Health insurance coverage in Mali implies coverage of reproductive health, as the benefits package is likely to cover services available at first and second-level facilities, as well as referred hospital care. C-sections will thus be included. A dialogue within the government among the stakeholders of the two financing initiatives is needed to ensure better harmonization, and an eventual transition from exemption to insurance might serve as an opportunity to address remaining utilization barriers (such as transport costs, which could eventually be included in the benefits package).

"WHY DIDN'T WE FORESEE THESE PROBLEMS? WE WERE OPTIMISTIC AND THERE WAS A STRONG POLITICAL ELEMENT. HIPC FUNDS WERE THERE AND THE DONORS WERE EAGER. THERE WAS NO SENSE OF RESOURCE CONSTRAINTS."

– KEY INFORMANT, NATIONAL LEVEL

Figure 4.2 attempts to summarize some of the key features of free care policies and health insurance as they apply to financing reproductive health.

FIGURE 4.2 | SUMMARY: FREE CARE POLICIES AND INSURANCE AS MECHANISMS FOR OVERCOMING OBSTACLES TO REPRODUCTIVE HEALTH CARE

Financing strategy	Advantages	Disadvantages	Conditions for effective implementation	Other considerations
Free care policies	Makes services affordable to all Reduces delay from seeking cash Protects against indebtedness from care seeking Increases service use by poor people Avoids need for exemptions on other basis	Risk of informal charges HHs may not respect the referral system Does not cover transport and time costs If capacity not increased to address additional demand (health staff workload, availability of drugs and medical supplies) may result in declining quality Does not take into account or include private sector service provision Uses scarce resources to subsidize higher- as well as lower-income users	Adequate, long-term, stable funding source(s) Need for lost resources at local level to be replaced by additional government revenue Investment in staff salaries and drugs and medical supplies	Targeting to poor could reduce cost of policy Including reimbursements of private providers would broaden consumer choice, provide incentives for quality, and reduce burden on public facilities
Insurance	Allows households to pay when they can Reduces uncertainty and delay from seeking cash Protects against indebtedness Possible to subsidize coverage of priority and vulnerable groups	Certain RH services (normal pregnancy and delivery-related, for example) not typically "insurable risks" Premiums may not be affordable to all (risk of coverage gap) Cannot oblige informal sector populations to join	Government or donor subsidy or both Cross-subsidy from other services Benefits package attractive to population - delivery care and other RH services included in package Sliding premium (or even subsidized premiums) according to ability to pay or by geographic region/target population Possibility of including transport costs Match premiums plus subsidies to costs of services covered	Quality assurance or accreditation mechanisms an important complement Claims processing and audit important (and, often, challenging) to ensure the functioning of the system and to minimize fraud and abuse

5 CONCLUSIONS

While the body of empirical evidence remains relatively limited at present, it seems clear that both free care initiatives and health insurance – if implemented effectively – can have a positive and relatively rapid effect on utilization and therefore on certain health indicators, such as the proportion of assisted deliveries. Empirical evaluation of the impact of financing strategies on health indicators is best documented in Ghana and Rwanda (especially Ghana's exemption for deliveries and Rwanda's insurance coverage through mutuelles). Rigorous evaluation needs to be built in from the onset of financing strategies, and while this often correlates with significant collaboration and (co-) financing from an international partner organization at the start, it requires sustained commitment and effort from governments.

While the design of any financing strategy is important, it is often problems in implementation that derail effectiveness. These strategies are complex undertakings, and they require support, supervision, and an eye to evolution and adjustment over time. Using multiple financing strategies at the same time is feasible and appropriate if they are coordinated within an overarching financing strategy, and of course, not overly burdensome from an administrative and financial perspective. But a longer-term vision should not be neglected, no matter the pressure for short-term gains and maximal progress toward MDGs. The phasing of financing mechanisms – gradually moving from exemptions to insurance coverage, for example – may also be an answer to ensuring financial sustainability over time, while still jump-starting progress.

Ultimately, the question of sustainable financing must be answered, and on this front, experience in Africa is especially thin. Some twenty years ago in Bamako, user fees became one such financing mechanism – a strategy to address a health sector short of resources of all kinds. Today, our challenge is to ensure adequate overall funding of the health sector and appropriate utilization of health services by those in need, yet without overburdening households financially. There are likely short- and long-term solutions to this challenge, and as such, governments and their partners must engage in an evolutionary process toward long-term sustainable health financing.

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