International Labour Organization

Technical Note 2

December, 2020

International review of financial protection in maternal health care

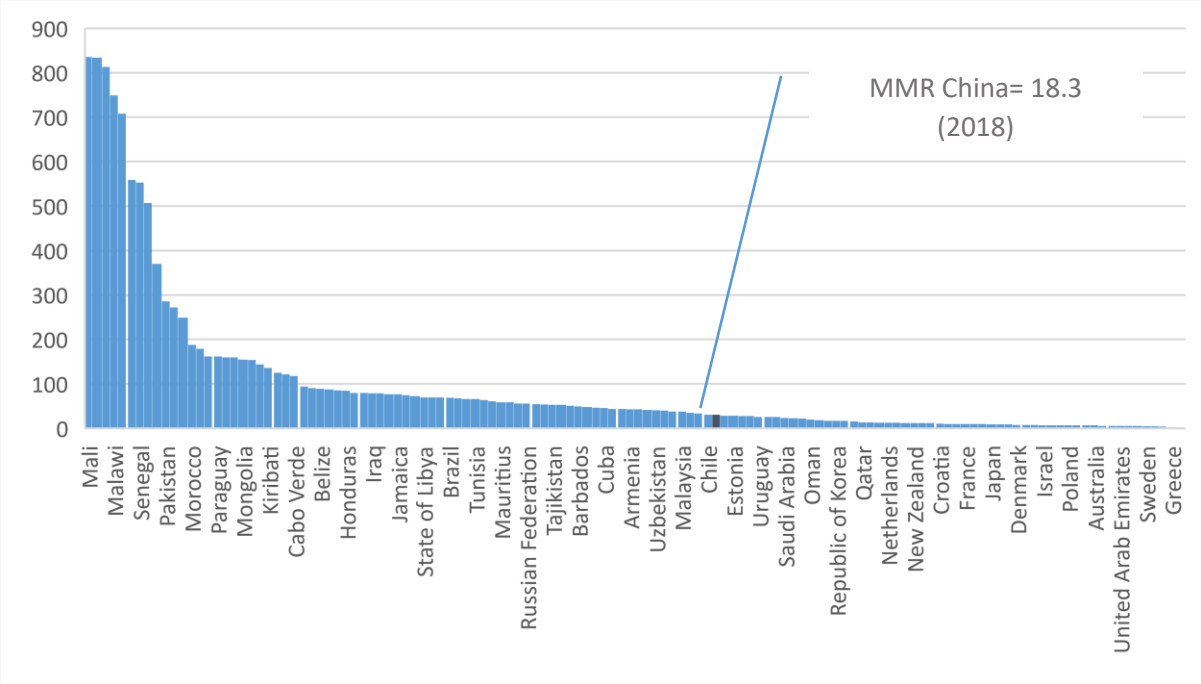
Key Points

- Maternal deaths during birth remain high in lower and middle income countries. In the context of maternity care, high costs borne directly by women put them at risk of delaying or foregoing antenatal and postnatal care, which is often associated with poor health outcomes for women and babies.
- In Europe, most countries provide free health care for pregnant women for pre-natal and post-natal care, delivery, hospitalization and medicine related to maternal care.
- China has reduced maternal mortality rates and out-of-pocket expenditures (OOPs) on health over the past twenty years, which holds valuable lessons for developing countries. However, OOPs per capita are still growing. Moreover, there are individual disparities accessing maternal care between women in different locations and in different forms of employment. Finally, an increased ratio of high-risk pregnant women poses a challenge to sustain reductions in maternal mortality ratio (MMR). The financial protection of women is limited in such situations.
- This technical note was motivated by and expanded on the assessment of the compatibility of law and practice in China with the ILO standards on maternal health care in the Social Security (Minimum Standards) Convention, 1952 (No. 102). It seeks to explore the causes of these OOPs and proposes some ways forward.

Introduction

An estimated 303,000 preventable deaths occurred during pregnancy and childbirth in 2015 globally, mostly as a result of pregnancy and birth-related complications (Mori et 2020:2).[1,2] In face of this grim reality, the Sustainable Development Goal (SDG) health target SDG 3.1 recommends "by 2030, (to) reduce the global maternal mortality ratio to less than 70 per 100 000 live births". Globally, the trend has been positive. Maternal mortality ratio (MMR) fell by 38 per cent between 2000 and 2017, from 342 deaths to 211 deaths per 100,000 live births worldwide. However, the level of maternal deaths during birth remains high in many countries (See Figure 1).

FIGURE 1. MATERNAL MORTALITY RATES IN SEVERAL COUNTRIES, 2017



Source: WHO, 2017

Note: MMR China: 18.3 in 2018 according to China Maternal and Child Health Development Report, 2019

In response to these challenges, World Health Organization (WHO) envisions that 'every pregnant woman and newborn infant receives good quality care throughout pregnancy, childbirth and the postnatal period', where quality refers to provision and experience of care from a health systems perspective. This technical note discusses international experiences regarding the composition of maternal health care packages and financial protection of women accessing health care before, during and after childbirth. It then dwells on the case of China in comparative perspective.

[1] https://unstats.un.org/sdgs/report/2020/goal-03/
[2] https://www.who.int/sdg/targets/en/

The major complications that account for nearly 75% of all maternal deaths are, according to the WHO,[3] severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications from delivery and unsafe abortions. In addition, WHO reports that there are high levels of maternal health morbidity worldwide which affect long-term health outcomes.

Birth attendance by a health professional is identified as a key factor to avoid complications and improve the health outcomes for both mother and child.[4] In some countries, attendance at home is supported in case of uncomplicated delivery and is covered by social health insurance. But for practical reasons obstetrical and midwife services tend to be concentrated in medical facilities, especially in developing countries, giving an incentive for women to do pre-natal care and birth in medical facilities. This can add to costs in accessing maternal care.

Out-of-pocket payments (OOPs) borne directly by households before, during and after childbirth, influence women's access to health care and therefore health outcomes (see definitions in box). High costs of care borne by health care users are often associated with forgone care. In the context of maternity care, financial burdens put women at risk of delaying or forgoing antenatal and postnatal care, which is often associated with poor outcomes for women and babies. The costs of morbidity with complications can be high.[5] In this context, and considering the impact on health outcome of maternity care, it is crucial to consider, as a priority, measures to overcome possible financial barriers of access to pre and post-natal care as well as delivery.

OOPs can be linked to several factors. We distinguish three main sources:

1. **Existence of official user charges** (i.e. charged by health facilities) **or co-payments** (i.e. amounts not covered by social health insurance or private health insurance schemes or in case of no insurance). Besides of contributing to the facilities' revenues, these official user charges and/or co-payments intend to control the risks of cost escalation due to moral hazard and overuse (see box). For example, they are price signals to help drive consumption towards drugs with a better cost-effectiveness, through the application of differential cost sharing rates to different medicines. They also

GLOSSARY

Different concepts have been used sometimes inter-changeably:

Out-of-pocket payments (OOPs) are direct payments made by households for health care services. This excludes any prepayment for health services, in the form of taxes or specific insurance premiums or contributions and net of any reimbursements to the individual who made the payments.

User fees and **health care user charges** refer to the amount charged by the health care facility for service. In countries where there is a National Health Service, user charges are inexistent or very limited. In countries where there is a social health insurance (SHI) system, part or totality of those charges are covered by the SHI.

Co-payment refers to a predetermined share of user fee for health care services that remains at the charge of the health care user. Synonym of co-payment is **cost sharing arrangement.**

Deductibles are the amounts paid for covered health care services before an insurance plan starts to pay.

Pre-payment refers to the payment of premiums or contributions to medical insurance.

Moral hazard refers to increasing ones' exposure to risk or the overconsumption of a given medical service because the health care user does not bear the full costs of that risk. Overuse is the use of procedures, drugs or tests that offer no clear health gain.

[3] https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
[4] See WHO 2018 recommendations on intrapartum care and WHO 2016 recommendations on antenatal care and postnatal care. https://extranet.who.int/rhl/guidelines/who-recommendations-intrapartum-care-positive-childbirth-experience
[5] https://pubmed.ncbi.nlm.nih.gov/31655962/

contribute to rationalizing the use of expensive diagnostics procedures and to avoiding consumption of risky treatments in cases of less obvious health benefits. In the case of pregnancy, moral hazard is not an important risk factor while overconsumption of services induced by the provider of health care services can happen. Indeed, even in developing countries, there is a growing trend toward the medicalisation of maternal health care through specialised, generally technology-based models. Over medicalisation includes inter alia, routine electronic foetal monitoring, routine episiotomy, induction of labour and frequent use of Caesarean delivery, which can be expensive and may increase rates of complications[6]. However, control over these escalating costs are usually best addressed through revised standards of care, modification of medical liability policies, as well as adequate purchasing strategies rather than the establishment of co-payments or user charges. [7,8,9,10] In industrialized countries, co-payment levels are usually low and do not represent a significant funding mechanism in the total health budget. However, on an individual basis it may induce financial hardships, especially amongst lower income users of the health system.

2. **Informal payments to health care providers**. In countries or areas with poor resource-settings, where health care providers are inadequately paid, charging informal fees directly to health care users may constitute a major source of revenue for health workers and may serve to sustain the provision of health services. However, unregulated direct charges often constitute a major access barrier to needed health care and contribute to high OOPs generating problems of financial protection (see definitions in the box on page 3).
3. **Limited benefit package covered by collective financing mechanisms and/or limited network of service providers**. If the benefit package covered is very limited, people may seek health care interventions that are not covered and hence pay out of pocket. Likewise, if the package is generous but in practice the network of accessible medical facilities is limited (i.e. geographic distance, long waiting times, etc.) then health care users may seek medical interventions in facilities outside the network (i.e. usually private facilities with less regulated prices).
4. **When health care benefits are not portable across geographical areas** of the same country, for example migrant workers, may have to bear the related costs.

It is important to note that there may be discrepancies between legal and effective protection. Especially in lower income country settings, maternal or any health services may be defined to be

[6] Shaw D. et al. Drivers of maternity care in high-income countries: can health systems support women-centered care? The Lancet. 2016; 388: 2282-95.
[7] Ibid.
[8] Purchasing is the process of paying for health services. There are three main ways to do this. One is for government to provide budgets directly to its own health service providers (integration of purchasing and provision) using general government revenues and, sometimes, insurance contributions. The second is for an institutionally separate purchasing agency (e.g. a health insurance fund or government authority) to purchase services on behalf of a population (a purchaser-provider split). The third is for individuals to pay a provider directly for services. Many countries use a combination. WHO 2017 : 4
[9] Strategic Purchasing: The Neglected Health Financing Function for Pursuing Universal Health Coverage in Lowand Middle-Income Countries Comment on "What's Needed to Develop Strategic Purchasing in Healthcare? Policy Lessons from a Realist Review" Kara Hanson, Edwine Barasa, Ayako Honda, Warisa Panichkriangkrai, and Walaiporn Patcharanarumol.
[10] WHO Report on Health Financing 2010

free for the population. However, due to insufficient funding, these services actually are only insufficiently available to a relevant extent. This forces users to buy medicine and surgical equipment at their own expenses in cases facilities have run out of stock, to face treatment quality issues that lead to complications and eventually even higher expenses, or to resort to facilities outside of the covered network of providers that provide more stable quality of services but charge user fees. This increases existing inequalities.

It is also important to keep in mind that women may face greater challenges than men when having to make payments upfront to health facilities. They may not have the same weight in decision-making regarding resource allocation in the household which adds to a lesser financial capacity. International practice illustrates three important findings when designing maternity care benefits:

1. **Timely maternity care accessed at early stages and without delay is an efficient and highly impactful investment in terms of health outcomes.** Pre-natal visits and surveillance have yielded significant results in reducing complications and associated costs. By meeting women's health needs without delay, health systems can avoid having to provide at least some of the more intensive (and more expensive) care at a later stage. Postpartum care ensures prompt recovery and early identification and management of problems and contributes to health promotion including infant immunisation and advice on breastfeeding. These are considered high impactful long-term investments.
2. **The benefit to cost relation of the investment in maternal health protection is high for the health system and beyond**. The probability of using the services is generally limited to a small number of events during women's lifetime, for a limited period, which limits the cost of maternal health packages per individual compared to compensation offered in the case of other social risks (sickness, injury or old age for example). Furthermore, cost-benefit analysis (CBA) and extended cost-effectiveness analysis (ECEA) show that the value of maternal health care protection schemes is high due to their contribution in preventing maternal and infant morbidity in the short and long term.[11]
3. **Ensuring the highest level of financial protection (the lowest level of OOP) is crucial to improve effective access to maternity care for all.** In this respect, this note sheds light on some of the design features adopted by a number of countries to abolish user charges and co-payments for maternity care. Most industrialized countries and a growing number of developing countries tend not to charge co-payments or implement exemptions in user charges for maternal health care services. The ILO minimum standards recommend that maternal care shall be at no charge for the women. This note describes in more detail the situation in a group of countries in the world.

[11] https://www.who.int/pmnch/topics/economics/201303_econ_benefits_framework.pdf

International standards on maternal health protection

A number of international standards provide for maternity medical care. These include the Medical Care and Sickness Benefits Convention, 1969 (No.130) which provides rules governing national legislations protecting employees through the provision of medical care of curative or preventive nature and through the provision of sickness benefits; the Medical Care Recommendation, 1944 (No. 69); the Social Security (Minimum Standards) Convention, 1952 (No. 102) providing minimum standards for health care benefits as part of social security comprehensive system; the Maternity Protection Convention, 2000 (No. 183) providing higher standards and its accompanying Recommendation No. 190; and finally, the Social Protection Floors Recommendation, 2012 (No. 202).

Objectives of maternal health care. Convention No.102 (C102) establishes the objective that "the medical care … shall be afforded with a view to maintaining, restoring or improving the health of the woman protected and her ability to work and to attend to her personal needs" (Article 47). In this regard, the importance of not only the curative but also the preventive aspects of medical care in relation with maternity have been duly recognized. These provisions under C102 are also seen to cover three of the four pillars on which the WHO bases its policy recommendation regarding safe motherhood: "family planning, prenatal care, clean and safe delivery, and essential obstetric care." And they reduce the incidence of maternal mortality and morbidity and improve the survival rates and health status of new-borns. [12]

Content of the package. C102 sets out minimum levels of protection to be guaranteed in case of maternity medical care. In particular, medical care (Part II) comprises in respect of pregnancy and confinement and their consequences, a maternity medical benefit that includes at least (a) pre-natal, confinement and post-natal care either by medical practitioners or by qualified midwives; and (b) hospitalisation where necessary. However, ILO standards do not prescribe a list of items to be covered under maternity related medical care packages. As a minimum standard, the provisions of ILO standards are meant to accommodate the large majority of medical interventions in case of maternity, both through qualified practitioners and qualified midwives. The higher and most recent international standard related to maternity protection - the Maternity Protection Convention, 2000 (No.183) states that "Medical benefits shall be provided for the woman and her child in accordance with national laws and regulations or in any other manner consistent with national practice." (Article 7) Instead, the instruments intend to provide a framework for the definition of a health package through informed social dialogue. Ultimately, cost-effective interventions from a clinical and societal perspective are to be included. The WHO consolidates evidence in this respect and published guidelines accordingly.[13]

Complementarity of mechanisms and funding approaches in attaining social health protection. C102 recommends that institutions or government departments administering the benefit shall, by such means as may be deemed appropriate, encourage the persons protected to avail themselves of the general health services placed at their disposal by the public authorities

[12] Maternity protection at work: Revision of the Maternity Protection Convention (Revised), 1952 (No. 103), and Recommendation, 1952 (No. 95), Report V(I) Geneva, International Labour Office, 1997, p. 77

[13] WHO recommendations for antenatal and during childbirth provide a review of effective interventions and make recommendations both generic and context specific services. See Recommendation for antenatal care and Intrapartum care

or by other bodies recognised by the public authorities (Article 10(4) and 49(4)). Very much in relation to the need to ensure that medical benefits aim at restoring, maintaining or improving the ability of the person protected to work, the purpose was to emphasize the importance of cooperating with organized preventive health programmes. "Since general preventive health services are, as a rule, the responsibility of special Government departments, the agencies administering the medical benefit should, by all appropriate means, encourage the persons protected to make the best possible use of such general health services as may be placed at their disposal."[14] C102 also does not prescribe specific mechanisms for the provision of medical care and cash benefits. Rather, it acknowledges that the provision of medical care and cash benefits can be provided by various different mechanisms, some financed by contributions, others by taxes, or a combination of both, in relation with various categories of potential beneficiaries such as active women, dependent family members or national residents.[15] Medical benefits provided in case of maternity are covered whether this is by a general medical care service (Part II) or by a maternity scheme (Part VIII). Where the case may be, it is possible for maternity medical care to encompass not only the package included under the health pre-financed system (or medical health insurance mechanisms) as well as the package made available through national health systems without costs for users nor subject to reimbursement by medical insurance. In the field of mother and infant health care, there have been a number of state funded complementary vertical programs targeting these groups. The analysis of the application of the Convention in light of national law and practice must take into account the whole system of social health protection including maternal care provision under the public health and social health insurance systems.

What does hospitalisation, where necessary, mean? According to the ILO standards, where necessitated by the circumstances, in relation to the pregnancy, confinement and its consequences, hospitalization should be foreseen. When this provision was included, it was acknowledged that in some countries hospitalization is often the only means of bringing care to persons living in remote areas. That was due to the lack of doctors or clinics available, and the fact that domiciliary care is not possible, either because physicians are not available or even where they are, the housing conditions do not permit it. Hospitalisation was listed as it was seen as a more realistic response to providing a minimum level of care rather than providing general and even specialist care in the remotest parts of a territory.[16] In other words, given these varying levels of development of national health systems and the need to ensure access to at least a minimum level of care even for persons living in the remotest areas, hospitalization was considered necessary in reducing maternal and infant mortality to a minimum. In some countries, maternal care, including delivery at lower level health facilities or even at home, can be sufficient to meet the requirements of ILO standards.

[14] Report V(a) 2, p. 196

[15] In its article 71, 1 the ILO Convention No. 102 notes that t*he cost of the benefits provided in compliance with this Convention and the cost of the administration of such benefits shall be borne collectively by way of insurance contributions or taxation or both in a manner which avoids hardship to persons of small means and takes into account the economic situation of the Member and of the classes of persons protected*.

[16] Report IV(2), p 221

International practices in maternal health care packages

Quality maternal health services must be part of a continuum of care that spans from the pre-pregnancy to the postpartum period. WHO envisions that *'every pregnant woman and newborn infant receives good quality care throughout pregnancy, childbirth and the postnatal period'*, where quality refers to provision and experience of care from a health systems perspective. The WHO provides guidelines for all periods of pregnancy, childbirth and postnatal care.[17] However, maternal health care packages vary and reflect national priorities and circumstances.

Antenatal care. According to international experience, antenatal care comprises several points of contact with medical professionals (midwives or doctors). WHO guidelines contain 49 recommendations that outline what care pregnant women should receive at each of the contacts with the health system, including counselling on healthy diet and optimal nutrition, physical activity, tobacco and substance use; malaria and HIV prevention; blood tests to check for genetic conditions (such as sickle cell anaemia, thalassaemia or cystic fibrosis) and tetanus vaccination; foetal measurements including use of ultrasound for surveillance of the normal evolution of the baby; and advice for dealing with common physiological symptoms such as nausea, back pain and constipation.[18] Furthermore, antenatal information and education classes held in a group and conducted by a midwife are sometimes included in maternal health packages (Switzerland, China). Some countries include home pre-natal visits in the package. Midwifery has been recognized as a key contribution to a positive birth experience given by women's greater appreciation of quality of care, lower use of health interventions and the overall cost-effectiveness of midwife led birthing units.

Delivery. Delivery at home with assistance of midwives is part of compensated maternal care package for instance in Germany. These are ensured by highly trained personnel, with the ability to recognise and manage complications and administer emergency life savings measures for mother and baby. In the absence of this, and the lack of appropriate hygiene and safe conditions, delivery in health facilities has been encouraged in other countries. In this case, the cost of transportation to the health facilities can represent an important financial barrier in accessing timely care. Physical distance to obstetric services and transport costs are often cited in rural areas as deterrents to maternal care across the world (Banke-Thomas et al 2020). For example, in the United States, almost one woman in five is unable to have her first prenatal visit as soon as she wants it.[19] For those reasons compensation for transportation costs is included in some cases in maternal care packages (for example in the UK, France and Austria). The payment of stay in hospitals or waiting homes can also be significant for rural people. However, meals and hospital stays are not always included in maternal health care packages in developing countries and can constitute significant part of OOPs in maternal care.

There are increasing rates of caesarean delivery (C-section) in the world, with variations between and within countries according to women's socio-economic status and the capacity to access

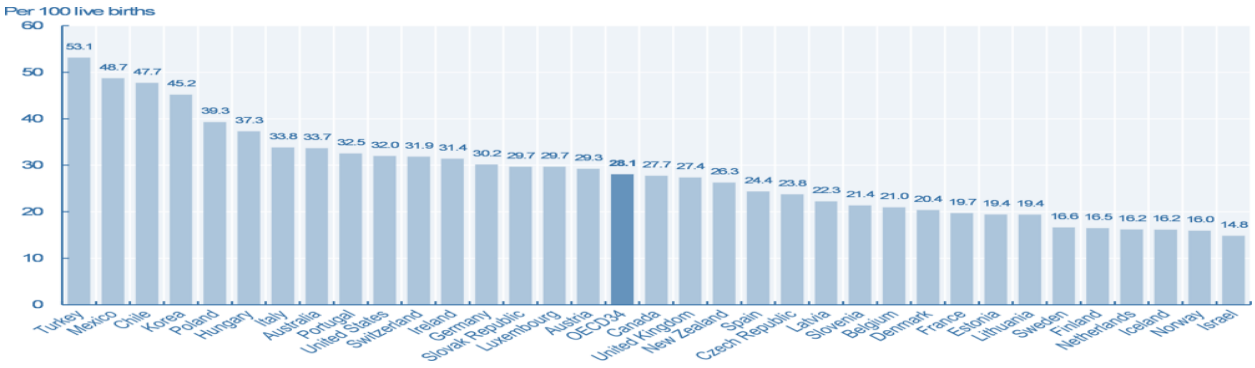
[17] WHO Recommendations on Maternal Health. Guidelines approved by the WHO Guidelines Review Committee, updated May 2017 https://www.who.int/publications/i/item/WHO-MCA-17.10

[18] https://www.who.int/news/item/07-11-2016-pregnant-women-must-be-able-to-access-the-right-care-at-the-right-time-says-who

[19] https://www.healthaffairs.org/do/10.1377/hblog20191203.960326/full/

medical facilities. This goes hand in hand with an increasing medicalization of the birthing process. C-sections are effective in reducing maternal and child deaths, but only in medically indicated reasons. Caesarean interventions themselves increase the risk of maternal mortality and carry risks in subsequent pregnancies for the health effects caused by C-section, such as uterine rupture, abnormal placentation, ectopic pregnancy, stillbirth, and preterm birth for women[20] (Sandall 2018). Therefore, the indication for a caesarean section needs to be formulated carefully, taking into account both benefits and risks of the decision. There are few absolute indications for a primary[21] C-section where the mother's life is directly at risk (if the foetus is positioned sideways, if there is a risk of uterus rupture or if the placenta is incorrectly positioned or detaches prematurely).[22] In all other cases, it is recommended to initiate labour and vaginal delivery first and decide on C-section only in the case of complications occurring and balancing health risks for mother and child, like imminent foetal asphyxia (lack of oxygen supply), protracted labour or impossibility of the foetus to pass through the birth canal. [23] The WHO recommends a caesarean section rate of not more than 10 to 15%,[24] but many countries are well above that standard (Figure 2). [25] The main drivers for this situation have been identified in high-income countries, while some of them are linked to epidemiological changes (such as increasing age of pregnancy, rise of non-communicable diseases, etc.), others relate to other factors, including models of care, fear and high medical liability costs, among others.[26]

FIGURE 2. CAESAREAN SECTION RATES (OECD), 2017



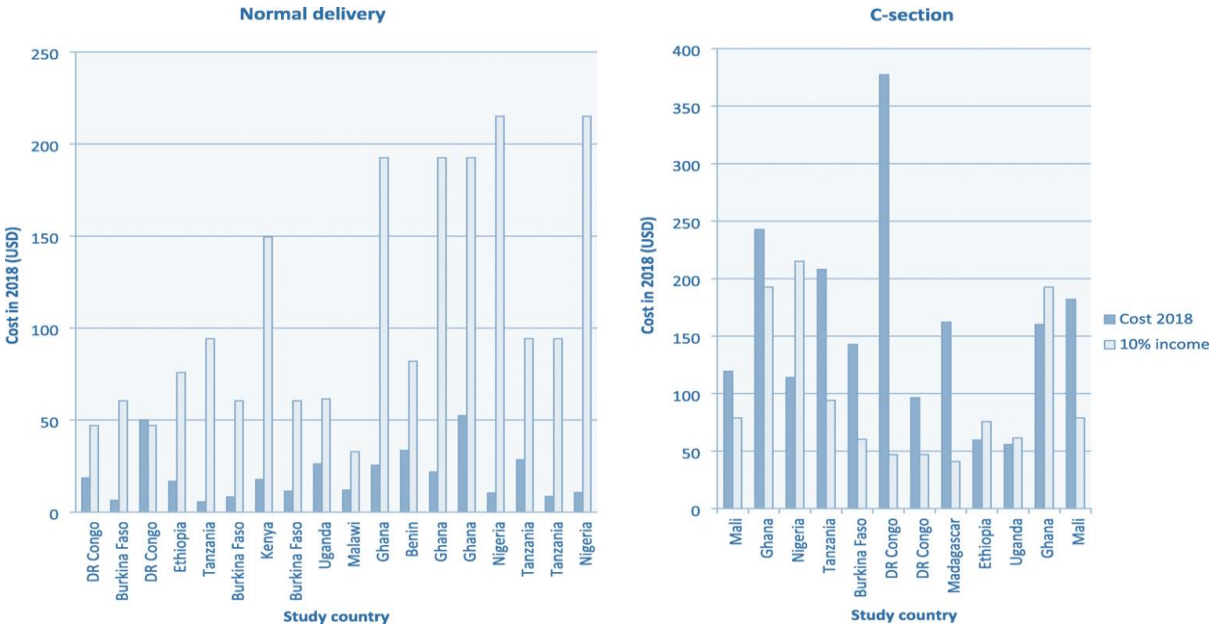
Source: OECD Health Statistics 2019.

Naturally, caesareans generate significant additional costs for the health system. In a survey of costs with deliveries in several provinces in Africa, Mori et al. (2020) showed that for normal deliveries, women pay between USD 5.6–52.4 and for C-section they pay between USD 55.8–377.3, meaning on average for the women it costs seven times more to deliver by C-section (Figure 3

[20] The risks of a caesarean delivery include bleeding, blood clots, breathing problems for the child, especially if done before 39 weeks of pregnancy, increased risks for future pregnancies, infection, injury to the child during surgery, longer recovery time compared with vaginal birth, and surgical injury to other organs.
[21] Primary C-section without trying vaginal delivery first.
[22] https://www.nice.org.uk/guidance/cg132/resources/caesarean-section-pdf-35109507009733
[23] https://www.rcog.org.uk/globalassets/documents/guidelines/goodpractice11classificationofurgency.pdf
[24] https://www.who.int/reproductivehealth/topics/maternal_perinatal/cs-statement/en/; https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1
[25] https://www.dw.com/en/doctors-warn-of-alarming-c-section-epidemic/a-45856378
[26] Shaw D. et al. Drivers of maternity care in high-income countries: can health systems support women-centered care? The Lancet. 2016; 388: 2282-95.

below). C-section rates are often included in maternal health care packages when they are medically prescribed but not always elective ones.

FIGURE 3. OOPS, NORMAL AND C-SECTIONS AND 10% INCOME IN SELECTED AFRICAN COUNTRIES, 2018



Source: Mori, Binyaruka, Hangoma, et al. 2020, p.12.

Note: countries indicated several times designate surveys in different localities.

Access to emergency curative care has become critical in industrialised and developing countries for different reasons. Many women each year need emergency treatment to save their lives while they deliver babies or immediately after, including blood transfusions, interventions for heart failure or stroke, or an emergency hysterectomy associated with birth. In industrialised countries, emergency care requiring life-saving treatment and hospitalization are due to mothers becoming older and the increased availability of medical technology that prevents and treats complications linked to diabetes, obesity or in case of multiple births.[27] In developing countries, pregnancy and childbirth complications continue to be among the leading causes of death. They are often due to insufficient equipment and technology and weak referral systems to higher level medical facilities.[28] Common complications such as obstructed birth**,** preeclampsia (high blood pressure during pregnancy) or excessive bleeding can kill the mother, the child or both. As each pregnancy magnifies the mother's health risks,[29] [30] women in developing countries suffer from higher risks of complications due to high fertility rates. The decrease in maternal mortality ratio in Latin America and the Caribbean can be attributed in part to better coverage of prevention and treatment of risk deliveries. MMR decreased from 88 per 100,000 live births in 2005 to 74 in 2017.

[27] Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15," *Health Affairs*. DOI: 10.1377/hlthaff.2019.00805

[28] https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

[29] https://edition.cnn.com/2011/11/01/health/multiple-pregnancies-mother/index.html

[30] https://healthcostinstitute.org/images/pdfs/iFHP_Report_2017_191212.pdf

For instance, Mexico's social security institute introduced free specialist pre-natal obstetric care and high-risk post-natal care in rural areas under its IMSS-Bienestar programme. The latter includes surgical emergencies deriving from complications during pregnancy and birth, available at second- and third-tier hospitals for insured women. 12 years after the reform, the number of deaths related to maternity complications fell from 113 per 100,000 pregnancies in 2007 to 28 in 2019.[31] (ISSA 2020)

Postpartum care. In the postpartum period, women experience a broad array of new-onset morbidities – including pain, exhaustion and infections – and in many instances these persist to six or more months after birth. Ensuring women have access to ongoing care before and after pregnancy, is also key to addressing underlying chronic conditions, such as hypertension, obesity and diabetes.[32] Some countries have broadened the exemptions under the maternity protection package to include such complications. Thus in Switzerland, women who fall ill during or after pregnancy (e.g. in case of complications) are no longer liable (since 2014) to any OOPs until 8 weeks after birth. This encompasses, for example, hospitalisation to avoid premature birth, treatment of gestational diabetes and infections or psychotherapy due to post-natal depression.

Finally, as prescribed in Article 49 of C102, complementary measures have been implemented to remove barriers and to encourage access to maternal health care. Over the past 12 years, Mexico improved the referral system and coordination between hospitals, to monitor risk pregnancies and reduce the risk of emergency interventions. In Peru, the Social Health Insurance Institute (EsSalud) monitors women at higher risk of complications during pregnancy using an Excel-based app that is integrated with the database of the Office for Planning and Quality. A booklet with a checklist enabled standardized prenatal check-ups using IT tools. Information booklets on maternal health were also provided to insured women in Spanish and other indigenous languages. The integration of patients' data reduced the administrative burden of higher-level supervisory staff. The recent period of COVID accelerated the process of digital administration in social security and medical care services that have greatly facilitated access of women to maternal health care.

[31] https://ww1.issa.int/news/gender-sensitive-social-security-americas

[32] Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15," *Health Affairs*. DOI: 10.1377/hlthaff.2019.00805

Systems of financial protection in maternal health

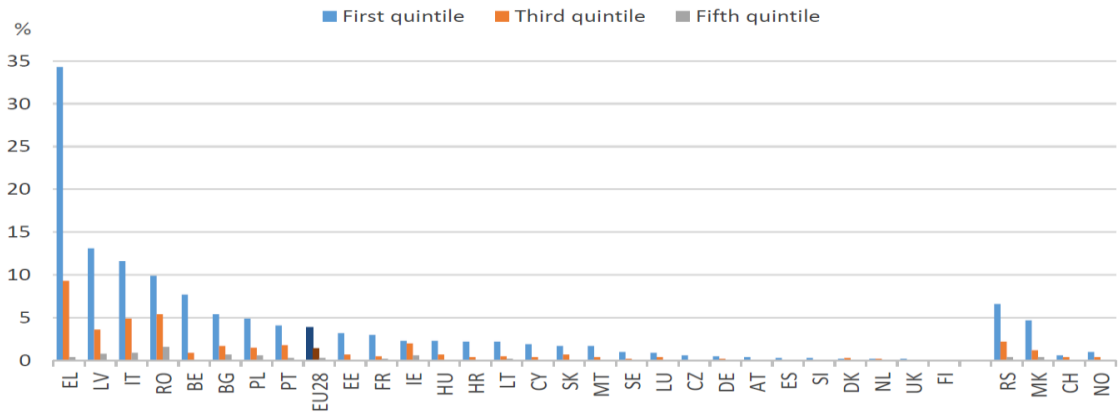
Overview of national responses

Countries have adopted a diversity of models to finance and administer access to health care. Originally, two mechanisms for financing health care access emerged: i) tax-financed medical care services whereby service is delivered for free in public facilities (such as the National Health Service in England) and ii) social health insurance based on contributions from workers and employers. In addition, some countries decided to adopt mechanisms based on private insurance whereby people are asked to contribute depending on their personal risks rather than their ability to contribute (i.e. not based on solidarity). In the 20th century those models have evolved and a combination of the two first mechanisms is usually being used in practice by countries. Beyond the diversity of models, there is today a wide recognition that:

- Collectively financed mechanisms with mandatory coverage embedded in the law are needed to reach universality of population coverage.
- A mix of funding sources with a strong role of general taxes is needed to ensure health services are accessible without high OOPs.
- A separation of provider and purchaser functions is necessary to ensure the best allocation of resources and to allow for the inclusion of a wide network of providers.

The choice of financing and administrative public model (medical care service, social health insurance, or a combination of both) seems to have only a limited impact on the design features of the health benefit package and financial protection, which are the main purpose of this note. Indeed, it seems that countries that have implemented an effective maternity care package with no user charges or co-payments have done so with a variety of financing and administration models. Figure 4 shows that well-performing countries can be found among all three models: for example, Austria and Luxemburg among the countries with a Social Health Insurance (SHI) system; and Spain and Norway with a National Health Service (NHS). (EU 2018 p.46).

FIGURE 4. SELF-REPORTED UNMET HEALTH NEEDS BY INCOME QUINTILE, 2016

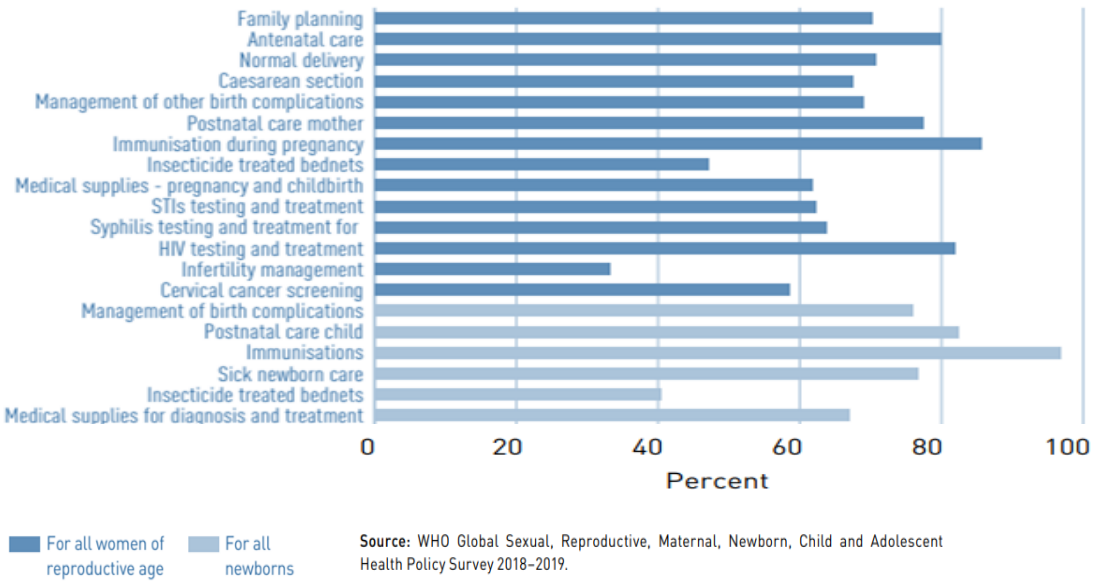


Source: EU 2018

One important differentiating factor is whether the package guarantees absence of user charges or co-payment for all or only for a category of the population. In a survey of 155 countries, WHO showed that many countries offer specific user fee exemptions for maternal, child and adolescent

health services at public facilities.[33] Figure 5 shows that most countries have no user fees for maternal and child immunizations (97%), antenatal care (80%), normal deliveries (71%), family planning (70%), and caesarean sections (68%).

FIGURE 5. FEE EXEMPTIONS FOR MATERNAL AND NEW-BORN HEALTH SERVICES AT PUBLIC FACILITIES (N=155 COUNTRIES), 2018-2019



This note distinguishes the following maternal health protection financing models:

1. **No user charges or co-payments for all. Four types of schemes:**
    a. National Health Services (NHS) – like in England, health services are free at the point of delivery in all public facilities. It is only possible in countries with a large and well financed public network, otherwise results would be in high inequity. NHS is financed by taxes.
    b. National Health Insurance (NHI) – like in France, initially a social insurance model but extended to all categories of households with tax financing supplement. Health services are paid by a third party (the NHI) for all. That allows to include private providers in the network and extends network of services.
    c. Categorical scheme for maternal and child health package – no user charges at the point of service only for women and newborn or children until 5, paid by taxes. This is now getting widespread in sub-Saharan Africa (i.e. Burkina Faso, Mali, etc.). Same as NHS, it requires extended public network of health care providers. It requires effective social control mechanisms to enforce free access.
    d. Mandated private insurance – like in Switzerland, the package is defined by law centrally, and then private insurers can compete for the market but only within the defined regulation. It requires very strong regulatory and control capacities and provides limited ability to perform strategic purchasing.
2. **No user charges or co-payment for specific categories:**

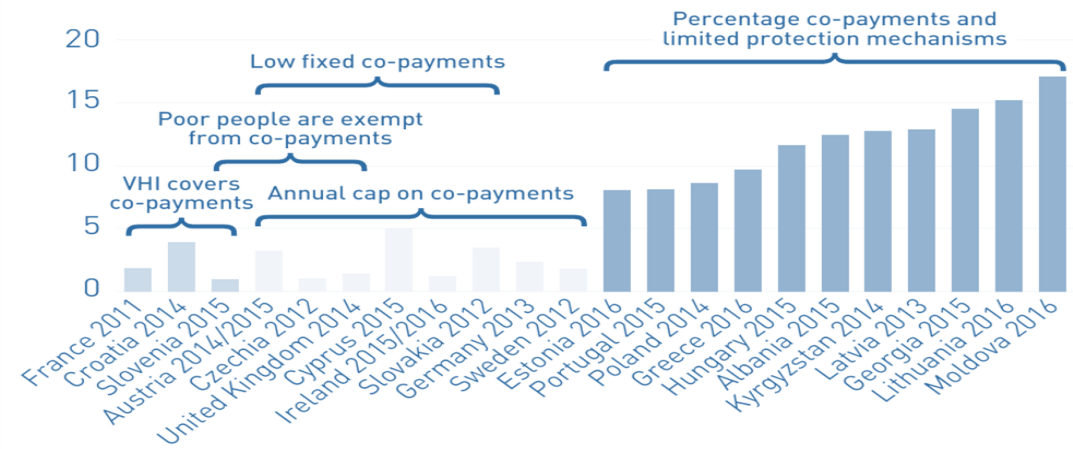
[33] WHO Global Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey 2018-2019.

a. For the poor. This is compatible with the four models described above, by adding targeting mechanism like a means-test to target the programme. The downsides include all of the classic pitfalls of targeting (exclusion errors, administrative burden, etc.) and lack of broad risk pooling.

b. For workers only. In countries where social insurance covers only a smaller part of the population, this leads to excluding large population groups. Most countries have moved on from this long ago but some low-income countries still have such categorisations in place. Small risk pool, limited solidarity and health equity.

WHO has classified different EU countries according to the incidence of catastrophic health care costs and the forms of co-payment limitations in place. Figure 6 shows the variety of mechanisms utilized to reduce co-payments and their effect on capping catastrophic health costs.

FIGURE 6. CATASTROPHIC HEALTH CARE COSTS BY COUNTRY (% INCOME) VERSUS NATURE OF CO-PAYMENTS



Source: WHO 2019, p. 48[34]

Cross country analysis

This note seeks to classify national health financing systems according to the type of co-payments required for maternal health protection. It draws on information extracted from MISSOC and the US SSA/ISSA databases, and secondary data from studies in OECD and developing countries. It seeks to respond to three questions:

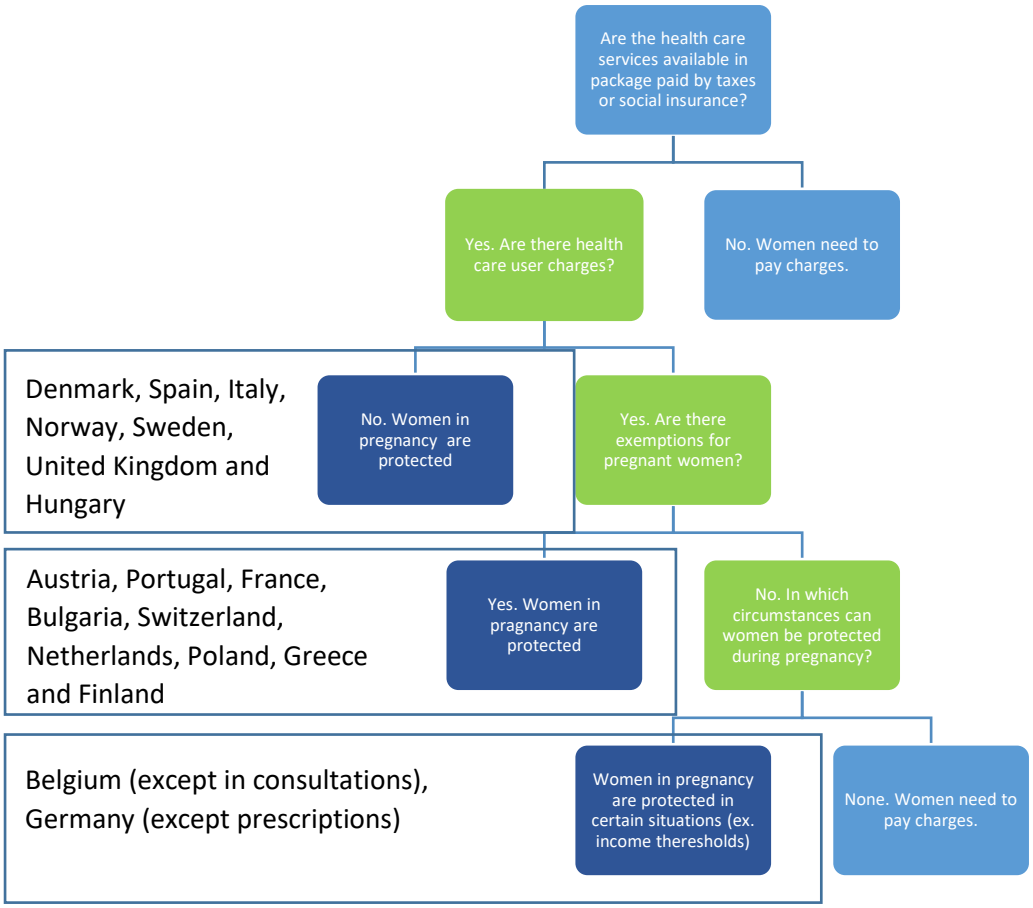
- **First question:** are the services available in maternal health packages guaranteed by the law? And how are they funded (i.e. by means of by taxes or social insurance contributions)?
- **Second question:** are there direct payments made by health care users (i.e. official user charges or co-payments)?
- **Third question:** are there specific exemptions for pregnant women?
- **Fourth**: If not, in what circumstances can they obtain free service?

The annex of this note presents the synoptic results table. Figure 7 gives the overview of the legal situation in Europe. Denmark, Spain, Italy, Norway, Sweden, United Kingdom and Hungary do not charge health care user fees. Austria, France, Bulgaria, Switzerland, Netherlands, Poland, Greece

[34] https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf

and Finland exempt pregnant women from charges. Belgium (except in consultations) and Germany (except prescriptions) provide exemptions in case health users are poor or in certain chronic conditions.

FIGURE 7. BASIC MATERNAL HEALTH CARE PACKAGE: PRE AND POST-NATAL CARE, AND NORMAL DELIVERY



Country cases

This section provides further detail by country distinguishing countries with no co-payments and countries with some co-payments in case of maternal health care.

Schemes with no user charges or co-payments for all

National Health Services schemes, mainly tax funded

In principle, systems that are tax-funded National Health Services (NHS) provide universal coverage based on residency. In addition, Denmark, Italy, Spain, Norway, Sweden, United Kingdom and Portugal do not have co-payment mechanisms in place.

In the **United Kingdom**, the NHS covers fully pregnancy and childbirth and maternity care is provided free of charge.[35] In **Denmark,** there is a NHS for all residents as well. For pre and post-

[35] https://maternityaction.org.uk/advice/entitlement-to-free-nhs-maternity-care-for-women-from-abroad-scotland-wales-northern-ireland/

natal care, there is free medical treatment by a general practitioner (GP) who works under collective agreement with the public health service. There are no user charges for treatment by the GP, or by a specialist to whom he refers the health care user. Normal delivery is free with midwife or hospital care. Hospitalization is free of charge at public hospitals, approved private establishments and private hospitals with agreement with the regional health authorities. There are no co-payments for pharmaceuticals as part of public treatment in hospitals. In **Norway,** there are free maternity services (pre and post-natal consultations) and hospital care (with no co-payment in hospitals). In **Sweden,** all pregnant women are entitled to free checks during the pregnancy. The first check usually takes place in weeks 8-12 of the pregnancy. People covered by social insurance in Sweden, do not pay for visits to the midwife or the doctor at the maternity hospital. At many health centres there is also a maternity clinic (in Swedish, mödravårdscentral, MVC), free of charge. Primary maternity and infant healthcare are thus free of charge for residents as well as delivery.[36] In **Italy,** medical doctor consultations are free of charge in case of pregnancy or maternity consultations under the NHS. There are also no charges for hospitalization under the NHS. In **Spain**, medical checks during pregnancy, care during birth and post-natal confinement and in case of complications are free of charge at the point of service. Hospitalisation in hospitals of the NHS *(*in Spanish, *Sistema Nacional de Salud)* or hospitals operating under agreement do not have co-payments.

Some countries with public health services implement co-payments to some health services but provide specific exemptions for maternal health care. For example, in **Portugal**, health care provided to the mother is covered under the NHS (condition of residence in Portugal) but maternity medical examinations and hospital care are provided without health care user co-payment. In **Brazil**, maternal health care is available to all Brazilians without user fees, co-payments or financial contributions under the tax-financed NHS (Brazilian Sistema Unico de Saude), except for pharmaceuticals. The latter are dispensed at cost values (below market values). **Argentina** provides free health care services in its public facilities although there are co-payments for medicines for some health care users. **South Africa** has a free maternal care policy in place that provides free antenatal care, delivery and postnatal care in public hospitals.

In a few countries, the exemption or gratuity for maternal care was (re)introduced in the past two decades in NHS but there is still evidence of high OOPs in practice. For example, **Kenya** abolished in 2013 all user fees on pregnancy related ante-natal, delivery including C-sections and postnatal services in public facilities. However, while free delivery services were implemented promptly, antenatal services were still being charged on the ground. Furthermore there have been reports on underfunded facilities, leading to stock-outs and compromised quality. In **South Africa**, there are also inequalities in access to maternal health care services along socio-economic groups and a rural-urban divide. In **Tanzania**, all maternal services (antenatal care, delivery, postnatal care) are free of co-payments in public hospitals. However, due to frequent quality issues/supplies stock-outs, health care users have to buy either supplies from private pharmacies sometimes, or they turn to private hospitals (usually faith-based) where they have to pay certain treatment fees but receive better (perceived) quality.

[36] https://bbstockholm.se/content/welcome-bb-stockholm

National Health Insurance based schemes

At their origin, systems based on Social Health Insurance (SHI) cover people who contribute to the system. In these systems, people in gainful employment (employees and sometimes self-employed) are therefore covered. In practice many countries have extended coverage also through tax funded benefits to other groups. In some countries, SHI schemes do not have cost sharing mechanisms in place in case of maternal health care. For example, In **Finland**, medical checks at maternity and child health care centres are free of charge during and after pregnancy. If pregnancy progresses normally, at least 8-10 check-ups are provided at a maternity and child welfare clinic with a nurse or doctor. Residents are entitled to free maternity and child welfare clinic services provided by the municipal health care centre at clinic or hospital during pregnancy and afterwards. There are at least 15 further postnatal check-ups at the maternity and child welfare clinic. In addition, 90% of wage-earners are enrolled with various occupational voluntary medical schemes. The schemes may be supported by public subsidies. They provide faster access, better quality and an increased choice of healthcare provider with limited or no cost sharing for maternity care.

VIDEO. WHY IT IS CHEAPER TO HAVE BIRTH IN FINLAND (CLICK ON PICTURE FOR YOUTUBE VIDEO)

Source: CNBC, 2020

In **Hungary**, maternity benefits include check-ups, delivery at home or in a hospital, advice on breast-feeding, home care services and family assistance. In addition, pharmaceuticals provided during health care are free of charge. There are no co-payments for delivery and hospitalization but some charges apply for hospitality items such as accommodation and meals. In **Bulgaria,** maternal care includes dispensary observation for pregnant women. Any person covered under the contribution-funded scheme pays the physician, dentist or health-care facility (providing medical care) a user fee for each visit. In case of hospitalisation of less than 10 days per year, any person covered under the contribution-funded scheme pays a user fee. After the 10th day, the health care user is not required to pay the user fee. Nevertheless, in the case of care and hospitalization for pregnant and young mothers, there is exemption of payment of fees granted, up to 45 days after birth. In **Poland**, maternal care package includes prevention and assistance during pregnancy, pre- and post-natal care, and care in hospital. There is free choice among doctors contracted by the regional National Health Fund (Narodowy Fundusz Zdrowia, NFZ) as well as a free choice of contracted hospital. However, to be covered by the scheme, hospitalisation is subject to referral by a contracted doctor. In **Czech Republic,** the maternal care package includes pre-natal and post-natal checks and care including free confinement and hospital care. Health care users are given direct access to public hospitals, which is not restricted by a gate-keeping system. There is free choice of contracted hospitals after referral by primary doctors or

specialist. There are no co-payments for confinement or hospitalization. There are co-payments only for medical devices. There are however exemptions for medical devices for persons in material need. Free pre-natal, post-natal and hospital care and confinement is provided.

In **France**[37], maternal care includes care during pregnancy and childbirth, as well as the following rest period for the mother. In the event of maternity, compulsory basic insurance covers medical examinations, pharmaceutical and hospital costs. All compulsory pre-natal examinations (compulsory prenatal appointments, birth preparation classes, and complementary laboratory tests), are covered at a rate of 100%. Moreover, between the sixth month of pregnancy and the twelfth day following birth, all medical expenses are covered at a rate of 100%, whether or not they are pregnancy-related. The mother is also exempted from the €1 charge and the flat charge for medications, paramedical services and travel. As from January 1st, 2017, the third-party payment system applies to all medical care that is covered by the maternity insurance system at a rate of 100% and provided by non-hospital-based health professionals. This means that the health care user does not pay for any care upfront as the health insurance (*Assurance Maladie* in French) pays the healthcare professional directly for the appointment or procedures performed.

In Austria, benefits are ordinarily provided by independent medical doctors, hospitals, and pharmacists under contract with sickness funds (health insurance). Some funds operate their own clinics or hospitals. Maternal health services include preventive examinations and maternity care, transportation, hospitalization, medicine and home care. There is free choice of doctors for pre-natal or post-natal consultations under contract with health insurances. There is free choice of public hospitals. Referral by a general practitioner or a specialist is required. Free hospital stay and care in a hospital in the case of maternity is also included. There is exemption from user fees for health care related to pregnancy and birth which include medical tests and pharmaceutical products. In **Greece**, since 2011, the newly created National Organisation for the Provision of Health Services (EOPYY) has brought together all the health branches of most social insurance funds. In 2016, health coverage was extended to the whole population, including uninsured groups such as the unemployed. Uninsured persons have access only to public health services, while insured persons also have access to private contracted providers, on a cost-sharing basis. However, there are exemptions for pregnant women. Doctor examinations are free of charge if made in public hospitals or laboratories of the EOPYY. Medication for pregnancy and confinement is free of charge. Insured women have the right to free-of-charge hospitalisation in a public hospital of the NHS.

Countries in South and East Asia, made significant progress in maternal health coverage to all the population in recent years, but in some cases, there are still some noticeable OOPs in practice. **Thailand** has achieved effective universal health coverage. The different schemes cover all periods of maternity (antenatal care, delivery/C-section, postnatal care) in public hospitals without any co-payments. The Universal Coverage Scheme covers 70% of the population and 2 other schemes cover the rest of the population. The benefit packages are nearly identical. **Philippines** has a NHI scheme, run by PhilHealth that covers approximately 90% of the

[37] https://www.cleiss.fr/docs/regimes/regime_france/an_1.html
https://www.informaternite.ch/en_attendant_bebe/l_assurance_maladie/prestations_de_l_assurance_de_base_en_cas_de_grossesse

population. Antenatal, delivery and postnatal services are fully covered. Additionally, the Philippine government has passed a law forbidding surcharges for PhilHealth covered services. However, a share of roughly 50% for OOPs within the total health expenditure of the Philippines hints towards actual payments the beneficiaries have to face at the point of service. **Indonesia** has reformed its various social health protection schemes in 2014 into one unified scheme, Jaminan Kesehatan Nasional (JKN) that covered 74% of the population in 2018. Under this scheme, maternity services are free in public hospitals. However, similar to Philippines, a high OOP share indicates some actual payments happening on the ground, despite laws forbidding extra charges.

South Korea and Japan do not have specific exemptions for maternal health care but services are subsidized on a lump sum basis, with some caps for excessive co-payments. **South Korea** has a National Health Insurance Service (NHIS) in place that covers the entire population. There are co-payments for all services at all levels of care, ranging from 20% to 60% of treatment cost depending on the level of care. Maternity care and treatment are not generally exempt, but subsidized to a maximum amount of 600,000 KRW (approx. 500 USD) per pregnancy. Excessive co-payments beyond 1.2 million KRW within 120 days are also covered by NHIS. In **Japan**, every citizen and resident is required to join the National Health Insurance. The insurance covers a broad benefits package, including antenatal childbirth care. Co-payments are 30%. Childbirth is fully covered up to an amount of 420,000 JPY (approx. 3,900 USD) by a lump sum payment to hospitals. **China**'s urban employee medical scheme resembles the South Korean and Japanese systems (lump sum provision to hospitals). The case of China is discussed in further detail in the next section.

Some countries in Africa have systems based in social health insurance, but these are not accessible to the whole population and OOPs remain high. For example, **Ghana** introduced the free maternal care policy under the National Health Insurance Scheme in 2008. The objective is to eliminate financial barriers associated with the use of services. But studies showed that similar to tax financed schemes in Africa, OOPs still exist in the midst of fee exemptions. Women make OOPs for drugs and other supplies such as disinfectants, soaps, rubber pads and clothing for new-borns as well. OOPs can be attributed to the delay in reimbursement by the NHIS.[38] In order to address these problems, **Burkina Faso** introduced in April 2016, a free health care policy for women. Instead of reimbursing health facilities, as many sub-Saharan countries do, the government paid them prospectively for covered services to avoid reimbursement delays, which were cited as a reason for the persistence of OOPs.[39]

Mandated private insurance schemes

Netherlands does not charge co-payments or deductibles in case of maternity. The basic package includes obstetric care (including medical checks and tests), outpatient health specialist care, hospital care and pregnancy care (prenatal, postnatal, as well as birth). Obstetric care is normally provided by a midwife, but may be provided by a general practitioner (GP) or specialist (if necessary in a clinic or hospital) when no midwife is available or when medically indicated. In the Netherlands, health care user charges for medical treatment (specialist referred by a GP, and for hospitalization) are subject to a compulsory deductible: all insured persons aged 18 years or

[38] https://pubmed.ncbi.nlm.nih.gov/29168019/
[39] https://pubmed.ncbi.nlm.nih.gov/30919219/

older pay a maximum of €385 per year. Yet, care from a GP, obstetric and maternity care are exempt from that compulsory deductible. In **Switzerland**[40] maternity health package includes pregnancy, delivery and recovery period of the mother thereafter. The system in Switzerland is rooted in the law, by which it is mandatory to have health insurance and the package and co-payment levels are defined by the State, but it is implemented by private insurers that are strongly regulated. Basic insurance envisages no co-payment for any maternity benefits. Before birth are usually covered 7 check-ups, 2 ultrasonic check-ups (11th to 14th and 20th to 23rd week of pregnancy), and there is a financial contribution toward antenatal classes held in a group and conducted by a midwife. During birth there is full coverage in the general ward of a hospital or in a birthing centre according to the hospital list of the canton of residence. The same applies in case of a home birth. Care at home by a midwife is covered up to 10 days after birth, 3 breastfeeding consultations with a midwife or a lactation consultant and 1 check-up (6–10 weeks after delivery) are also covered. In case of a high-risk pregnancy, basic insurance covers further measures if deemed clinically necessary. Women who fall ill during or after pregnancy (e.g. in case of complications) are no longer liable to any OOPs starting from the 13th week of pregnancy until 8 weeks after birth. This encompasses, for example, hospitalisation to avoid premature birth, treatment of gestational diabetes and infections or psychotherapy due to post-natal depression.

Schemes with no user charges or co-payment only for certain groups of population

In **Belgium**, the maternity package comprises pre- and post-natal care, monitoring and assistance during labour and delivery in a hospital or day hospital or at home. Delivery is of free access in public hospitals and hospitalization is free of co-payments in public wards of public hospitals. Pharmaceuticals of vital importance are accessed for free in such circumstances. There are however, co-payments for pre-natal visits (including imagery) and post-natal care. Charges amount to € 6 for general medical care and to € 12 for consultation with medical specialists. There are no special exemptions for pregnant women. However, there are several exemptions for people according to categories of income and vulnerable people (such as chronically ill, disabled, etc.).

In **Germany**, examinations for the diagnosis of pregnancy, auxiliary care and the assistance of a midwife during pregnancy and after childbirth are covered free of charge. There is also free hospitalisation in a shared room. There is a co-payment for hospitalization of €10 per calendar day during a maximum of 28 days per year, but hospitalizations for delivery are exempted. No additional payments are made in the case of pregnancy discomforts and in connection with delivery. There are co-payments per prescribed medicine, usually approximately 10% of the market price, but not more than 10 Euro. Total co-payments for health services are capped at 2% of annual earnings.

[40] https://en.comparis.ch/krankenkassen/eltern/info/glossar/mutterschaft
https://www.css.ch/downloadpdf.html?fileRef=%2Fcontent%2Fdam%2Fcss%2Fen%2Fdocuments%2Fsonstiges%2F3016_e_css_merkblatt_mutterschaft_classic.pdf&mimeType=application/pdf&_charset_=utf-8;
https://www.ch.ch/en/pregnancy-health-insurance-covers/

TABLE 1 – MATERNAL CARE SERVICES, THEIR AVAILABILITY IN THE MATERNAL CARE PACKAGE AND CO-PAYMENT, BELGIUM, 2020

	Pre-natal visits (incl. imagery)	Normal delivery (midwife or doctor)	Pharma-ceutical	Hospitalization	Post-natal care
Services available	Fees advanced by the insured person.	Delivery in a hospital or day hospital or at home.	Different categories of medicines.	Free choice of doctor. Direct payment of provider of care by the insurance body, if beneficiary is hospitalised.	Fees advanced by the insured person.
Cost sharing (general population)	Charges amount to € 6 for general medical care and to € 12 for consultation with medical specialists.	In principle, free choice among, and free access to approved hospitals. Complete refund in public ward. If not, health care user charges: * admission fee: € 43.52, * subsequently € 16.25 per day.	Categories of medicines of vital importance: co-payment set at 0% of the reimbursement base (ex-factory level),or free of charge.	In principle, free choice among, and free access to approved hospitals. Complete refund in public ward. If not, health care user charges: * admission fee: € 43.52, * subsequently € 16.25 per day.	Charges amount to € 6 for general medical care and to € 12 for consultation with medical specialists.
Exemptions (Maternal care)	Co-payment ceilings for different categories of income.	No	No	No	Co-payment ceilings for different categories of income.

Source: MISSOC, 2020

Other countries

Hatt et al. (2013) reviewed potential and documented benefits (increased use of maternity services) as well as risks (decreased provider motivation and quality of care) of user fee exemption policies for maternal health services in low income and fragile countries (Niger, Afghanistan, Burkina Faso, Ethiopia, Burundi, Ghana, and Mali). These countries have introduced exemptions for user fees for maternal health care since the 1990s. The authors show that removing user fees can have the detrimental effect in poorly resources environments, of reducing critically needed funding for health care services. Thus, a nominal increase in access to health care will not reduce mortality if the quality of facility-based care is poor. They recommend that Governments link user fee exemption policies with sustainable health financing sources to secure the replacement of lost revenue for facilities, as well as broader health system improvements, including facility upgrades, ensured supply of needed inputs, and improved human resources for health.

Lessons learned

It is desirable to avoid financial barriers of access to maternity care as it is an impactful health intervention.

Co-payment and user charges are not the best way to control for supply-side induced cost escalation, especially in low and middle-income countries (LMIC). While co-payments show some reducing effects on over-utilization in industrialized countries, they also induce general decreases in utilization for medically desirable prescriptions as well. This effect is more associated with lower income brackets.[41] [42] [43] In LMIC, co-payments are seen as the main cause of soaring OOPs and impoverishment due to sickness, forgone care and actually higher maternal and neonatal mortality. Adequate standard of care and an appropriate purchasing policy are best indicated in order to reduce not medically indicated and potentially harmful interventions and to improve cost-containment and increase utilization adequacy.[44]

In order to ensure financial protection and reduce OOPs, countries have adopted a diversity of mechanisms but they tend to have some common features, in particular:

- The definition of an explicit benefit package for maternity care with no co-payments or user charges embedded in the law.
- The mandatory nature of enrolment.
- Universality of coverage either through fully funded tax systems or a mix of contributory and tax funded systems, allowing all residents, including unemployed people to access maternal care, not subject to means tests.
- Minimal eligibility conditions to ensure wide coverage (i.e. no waiting periods).
- The need to have secured stable sources of funding for the health care system.
- The need for aligning strategic purchasing policies with evidence-based standards of care with a view to improve health outcomes and avoid harm.
- This includes specifically the establishment of efficient third-party payment mechanisms by which health care users do not pay for any care upfront.

[41] Cost-sharing mechanisms in health insurance schemes: A systematic review, October, 2011 (who.int)
[42] Effect of co-payment policies on initial medication non-adherence according to income: a population-based study - PubMed (nih.gov)
[43] The Effect of Co-payments for Prescriptions on Adherence to Prescription Medicines in Publicly Insured Populations; A Systematic Review and Meta-Analysis (nih.gov)
[44] WHO Report on Health Financing 2010

Maternal health protection in China

China has made notable progress in maternal health since the 1990s. The maternal mortality ratio declined from 88.8 deaths in 1990 to 18.3 per 100,000 live births in 2018,[45] achieving SDG 3 target to reduce MMR. Therefore, the Chinese experience holds lessons for other developing countries. Of particular notice are the investments in health care in rural areas that led to a convergence of MMR in urban and rural areas (Yang and Wang 2019). The MMR in China is fast approaching levels of industrialised countries but it is still above OECD average of 16/100,000 live births in 2016.[46] In addition, there remain some challenges in improving equity due to within country differences in financial protection in accessing maternal care.

Maternal care package (MHCP)

Public health service

The Law of the People's Republic of China on Maternal and Infant Health Care promulgated by Order No.33 on October 27, 1994 established a number of interventions in primary care that are essential for the prevention of mortality and morbidity and ensure medical follow-up of mother and baby. China's public health service program provides the following free pregnancy and postpartum examination services for all pregnant women.[47]

In the "National Standards for Basic Public Health Services (Third Edition)" promulgated in 2017, the contents related to maternal medical benefits include pre and post-natal maternal health care and health and family planning services. The contents of maternal health services include pre-natal care free of charge in primary care facilities up to 5 medical consultations per birth, free AIDS, syphilis, and hepatitis B screening for pregnant women nationwide, and 2 post-natal care interventions per birth, one involves home visiting and one is institution based.

In the "Newly Included Basic Public Health Services Related Work Regulations" (2019 Edition) the content related to maternal medical benefits includes basic contraceptive service items, supplementary folic acid to prevent neural tube defects, and national free pre-pregnancy eugenic health check items. The national free pre-pregnancy health check service provides free pre-pregnancy eugenic health check service including eugenic health education, medical history inquiry, physical examination, laboratory examinations, imaging examinations, risk assessment, counselling and guidance, early pregnancy and pregnancy outcome follow-up.

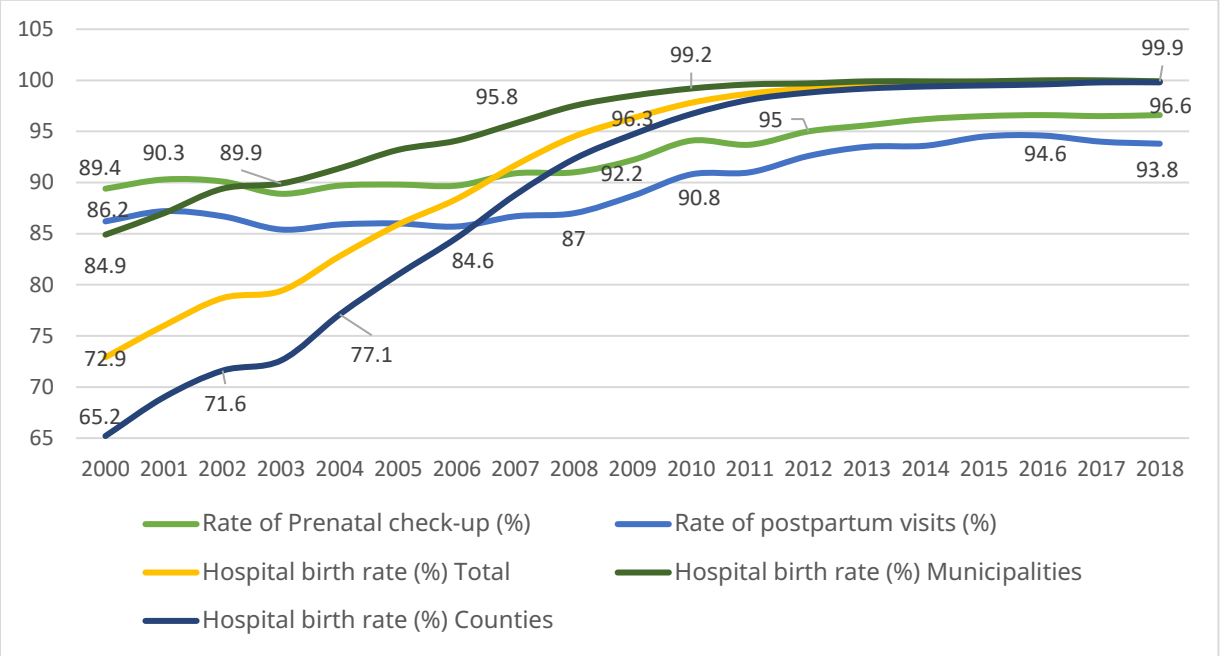
In addition, there are different vertical programs fully subsidized available to rural women, which helped curb maternal mortality in rural areas.

Most of township hospitals offer antenatal care as well as postnatal care. In recent years, the government has discouraged township hospitals to carry out delivery services as they did before. Women give birth mostly at obstetric clinics at county level (county hospitals).

[45] China Maternal and Child Health Development Report (2019)
[46] Maternal mortality ratio (modelled estimate, per 100,000 live births) - OECD members | Data (worldbank.org)
[47] 3rd version of the PHC guideline, 2017

The rates of necessary pre-natal and post-natal consultations have seen a steady increase over the past two decades and reach currently close near universal coverage. Hospital birth rates are encouraged and also reach near 100% of births.

FIGURE 8. RATES OF PRE-NATAL, POST-NATAL CONSULTATIONS AND HOSPITAL BIRTH RATES, 2000-18



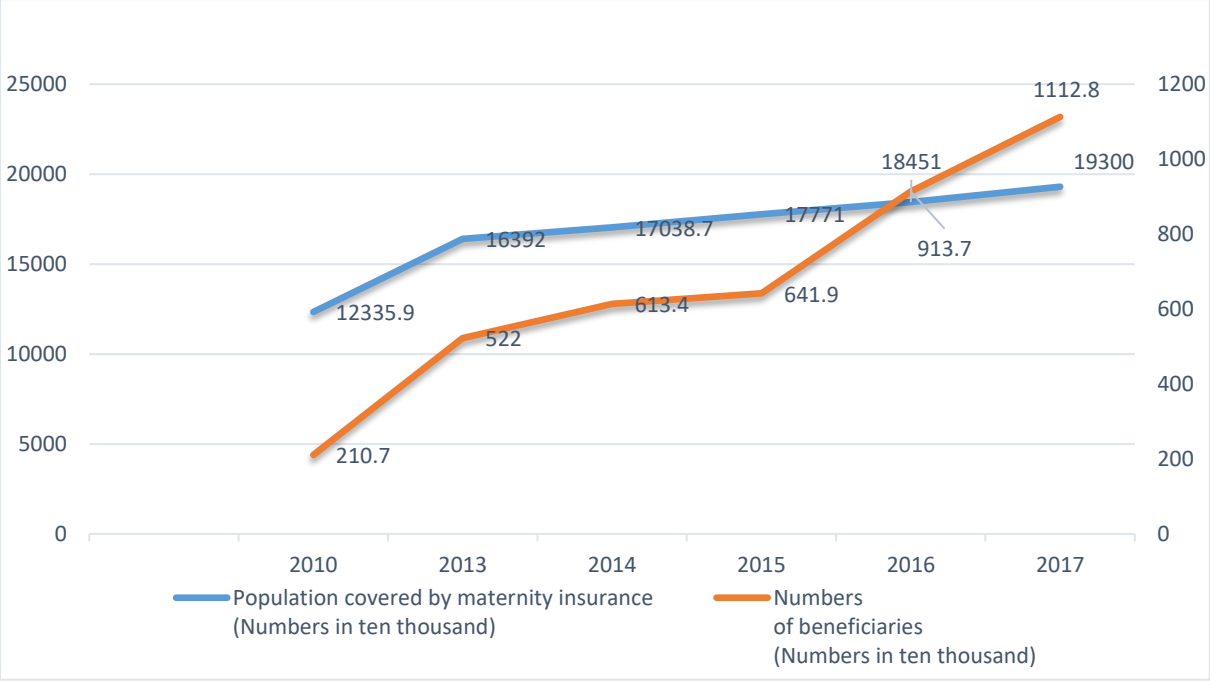
Source: China Health Statistical Yearbook 2019

Social insurance

Maternal medical insurance is provided to women covered under medical employee insurance or resident medical insurance schemes. According to medical social insurance regulations, delivery is covered with no cost for women up to certain amounts. The Social Insurance Law 2011 provides that "medical expenses for childbirth include the following: medical expenses for childbirth, medical expenses for family planning, and other service expenses prescribed by laws and regulations." The number of women covered by maternity insurance have steadily increased in the past decade, with a steeper increase in the number of beneficiaries, reaching 193 million and 111 million women respectively in 2017.

The specific benefits are based on the "Trial Measures for Enterprise Employees' Maternity Insurance." (Labour Ministry [1994] No. 504) Article 6: "The fee for examination, delivery, surgery, hospitalization and medicine for female employees shall be paid by the maternity insurance fund. The excess of medical service and medicine expenses (including self-paid medicines and nutritional medicines) shall be borne by the employees themselves. After the female employees are discharged from the hospital, the medical expenses caused by childbirth shall be paid by the maternity insurance fund; medical expenses for other diseases shall be handled in accordance with the provisions of medical insurance benefits." Consequently maternity medical expenses within the prescribed scope are paid by the maternity insurance fund, that is, individuals do not

FIGURE 9. COVERED POPULATION AND BENEFICIARIES OF MATERNITY INSURANCE, 2003-17



Source: China Health Statistical Yearbook 2019

within the prescribed scope are paid by the maternity insurance fund, that is, individuals do not pay the expenses with the exception of complementary needs such as nutritional supplements and other diseases not related to childbirth.

The relevant content can also be seen in the provisions of the "Maternity Insurance Measures (Draft for Comment)", 2012. Among them, Article 12 stipulates that "Medical expenses for childbirth include medical expenses for childbirth, medical expenses for family planning, and other service expenses that shall be paid by the maternity insurance fund as required by laws and regulations." Article 13 stipulates that "for participants in maternity insurance, their maternal medical expenses incurred in the contracted medical service institutions shall be paid by the maternity insurance fund if it meets the maternity insurance drug catalogue, diagnosis and benefits items and medical service facility standards". Those in need of emergency benefits or rescue can seek medical benefits at non-contracted medical service institutions, in which case under users can enjoy the same reimbursement as in the contracted institutions. The official interpretation of this policy document shows that this article can be understood as the maternity insurance fund pays for the medical expenses of the childbirth within the prescribed scope, that is, individuals do not pay the expenses.

But it also needs to be stated objectively that at present, the specific payment standards and payment methods of maternity insurance in China are governed by each province or city. Although the provincial documents do not stipulate the need for personal out-of-pocket expenses, in practice, it is understood that the medical expenses paid by maternity insurance due to childbirth are basically paid in a fixed amount. Some provinces clearly require no cost-sharing in second-level and lower medical institutions; individuals are required to bear a certain proportion of expenses incurred in the third-level medical institutions. If the fixed payment is

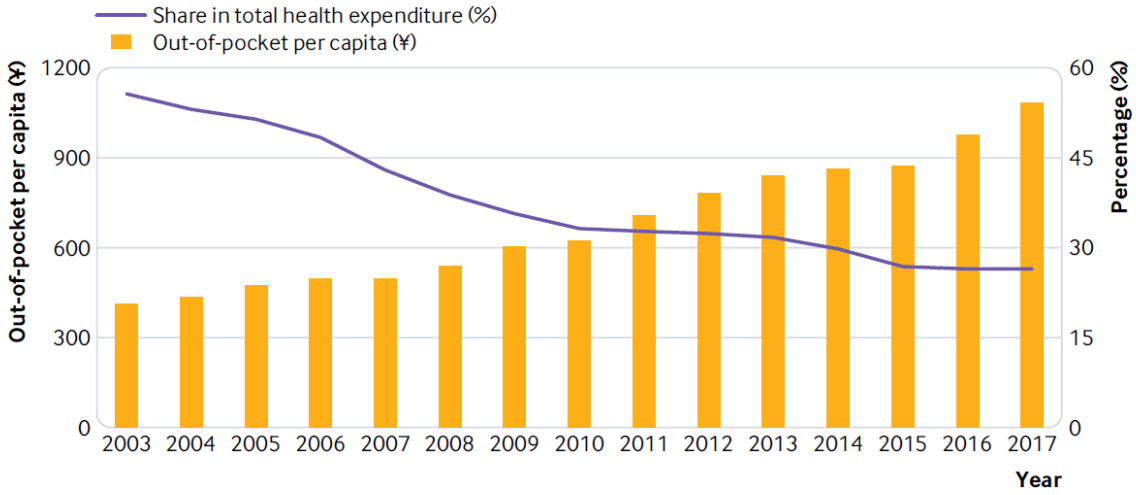
sufficient to guarantee the provision of basic maternal medical services, it should also be understood that there is no cost sharing for maternal medical expenses.

In conclusion, in law, China does not appear to require OOPs for medical maternity care. In practice, the compensation for such medical care is capped at certain fixed amounts with substantial differences between employees and residents' schemes. Specifically pre-natal, confinement and post-natal care either by medical practitioners or by qualified midwives are covered. Hospitalisation is not covered by public health system but is covered by social health insurance schemes. If the pregnancy is normal, and can be delivered in a low level institution or by home delivery with a midwife, this does not pose in general a financial charge to women. In practice, deliveries at secondary level hospitals, where they take place most frequently are effectively entirely covered. When emergency treatment is indicated such as when necessary caesarean is required because the baby is breech, such treatment is also covered legally. However, in practice, the limits may be overcome, which can have detrimental effects on financial protection of women.

Financial protection with MHCP

China achieved near-universal national health insurance coverage, with more than 95% of the Chinese population covered. In particular, the country increased dramatically medical insurance coverage by protecting the unemployed, the self-employed and rural populations. As a consequence, the share of out-of- pocket health expenses in total health expenditures fell from 56% in 2003 to 29% in 2017. It is projected to decrease further to 25% by 2030. However, the level of OOPs is far approaching but above the average of industrialised countries (OECD average 21% in 2016[48]). However, despite the fall of OOPs share of health expenses, the amount of OOPs per capita has actually increased (see Figure below). Moreover, there are inequities in the OOPs faced by different groups of women according to their residence and occupation status.

FIGURE 10. LEVEL AND SHARE OF OUT-OF-POCKET EXPENSES IN TOTAL HEALTH EXPENDITURES, 2003-17



Source: Fang 2019, p.2

[48] OECD-Focus-on-Out-of-Pocket-Spending-April-2019.pdf

Limitations of residence based medical coverage

In 2016, the State Council "Opinions of the State Council on Integrating the Basic Medical Insurance System for Urban and Rural Residents" unified the maternity medical benefits for urban and rural residents under a universal basic medical scheme. Unemployed women living in rural areas are covered by the subsidies of the basic residence medical scheme. The purpose of these subsidies is the same as the maternity insurance: to provide basic economic and health aids to pregnant women. Both maternity insurance and subsidies reimburse a lump sum amount per pregnancy and delivery (vaginal delivery or caesarean section). However, there are differences between the residence and urban employee's coverage and, in general, for the specific amounts of compensation for maternal health care costs within the country.

Limitations with financial protection associated with accessing outpatient care and hospitalisation at higher tier health facilities. First, the benefit package of residents' medical scheme is mostly limited to catastrophic and inpatient health care. Outpatient consultations are covered, with reimbursement usually limited to 100-400 Yuan per year. Secondly, the reimbursement rate varies across the level of healthcare facilities. If health care users go to a small hospital or clinic in their local town, the scheme will cover typically from 70–80% of their bill. At county level, the percentage of the cost being covered falls to about 60%, and if women need a specialist help in a large modern city hospital, they have to bear most of the cost, as the scheme would cover only about 30% of the bill. Therefore, there is generally limited protection beyond a basic package of maternal care, in the case of consultation of outpatient health care, specialists or prolonged hospitalisations for example in case of complications. This is increasingly problematic as, similarly to industrialised countries, the number of at risk births is on the rise due to chronic conditions, such as hypertension, obesity and diabetes.

Lower reimbursement rates result in higher OOPs for rural, non-employed and self-employed women. As a result of different reimbursement rates, OOPs for urban non-employed, self-employed people as well as rural populations are higher than for urban employed people. Employee maternity insurance and subsidies reimburse a lump sum amount per pregnancy and delivery (vaginal delivery or caesarean section). In general, for the specific amounts received normally pay expenses to approximately 3,000-4,000 Yuan, while under the residence maternity scheme, the reimbursement totals approximately 500–1,000 Yuan.

Migrant workers access to maternal care is more difficult. Rural migrant workers have trouble receiving compensation for their medical expenses that occurred away from their homeland. The case of the floating population of internal migrant women is noteworthy. In some cities like Shenzhen or Dongguan in the South of China, migrants constitute half of the population. Migrant women with full time official employment with a labour contract are eligible for maternal health coverage included in urban employee health insurance. But this does not apply to the majority of female migrant workers who often have part time or temporary jobs or work in the informal sector. In general, migrant women are not eligible for the urban employee health insurance that is available to people born in their receiving communities. They are only eligible for resident health insurance in their sending communities. But such health insurance does not directly cover

all services outside their home towns. In some circumstances, they can pay out-of-pocket for health care in their receiving communities and submit bills for reimbursement, but the process is cumbersome and reimbursement rates are incomplete and variable.

Limitations of urban employees medical schemes

MHCP covers a basic maternal care package

The amounts of reimbursement in urban employee insurance allow to cover a basic package in public hospitals. In the largest metropolitan areas in China, parents-to-be who are employed and have a labour contract (including migrants), can access maternity care mostly free of charge at a public city hospital. In this case, a woman can give birth and stay in a shared standard ward. In this scenario, the delivery itself will likely cost around 4,000-5,000 Yuan. This amount can be reimbursed by the urban employee medical scheme in form of a lump sum reimbursement. The value is reviewed from time to time and is expected to cover the full amount of medical maternity costs.

Insufficient financial protection in case of emergency hospitalisation, non-elective C-section and other needed maternal health care due to the association of chronic diseases

Several authors indicate that the amount determined as a lump sum compensation for hospitalisation may be insufficient to cover complications associated with births and C-sections. The case of compensation in case of emergencies could also be further clarified.

C-section rate accounts for 36.7% of deliveries but this varies and in some provinces it can reach 70% (2018 MCH surveillance data). The rates have reduced significantly over the past years,[49] but they are still above the international criteria whereby rates above 15% are considered as not medically justified (i.e. elective).[50] Thus, C-sections are being performed at a rate that is sub-optimal for the well-being of women and their babies. In China, studies have shown that Caesarean deliveries on maternal request (CDMR) represents a sizeable part of the interventions. CDMR comprised 10% to 28% of all caesarean deliveries in 2011.[51] There are significant variations in CDMR between provinces and levels of care. More recently, Wang wet al (2017) found that up to 40% of C-sections can be elective.[52] Studies demonstrated that women's reasons for choosing caesareans included anxiety about labour, fear of pain, choice of an auspicious delivery date, and demand for a controlled birth outcome, but there are also indications that it can be induced by supply (shortage of midwifery and medical staff). Because C-sections are frequent, an important share of the deliveries have high out-of-pocket costs for households and may have a greatly impoverishing effect. In 2016, a sample of 398 hospitals surveyed showed the cost of caesarean sections in public hospitals (median 5,000 Yuan) was twice as high as the cost of vaginal deliveries (median 2,500 Yuan).[53] However, there is some discussion about the need to differentiate C-

[49] https://www.bbc.com/news/world-asia-china-46265808
[50] https://www.who.int/reproductivehealth/guidance-to-reduce-unnecessary-caesarean-sections/en/ and https://www.who.int/mediacentre/news/releases/2015/caesarean-sections/en/
[51] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5716234/
[52] https://www.researchgate.net/publication/334114749_Caesarean_deliveries_in_China
[53] https://www.bmj.com/content/360/bmj.k817

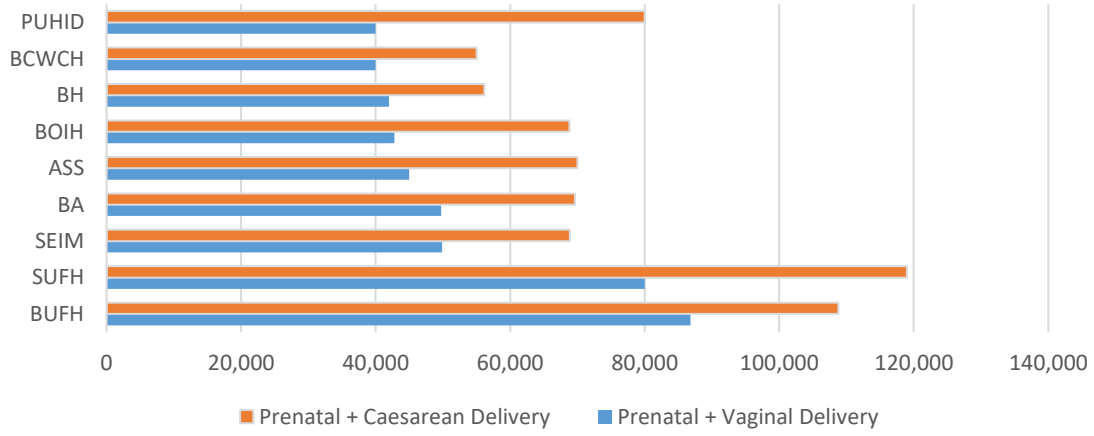
sections according to whether they are medically required or they are requested by mothers or result from a medical staff shortage. In some developing countries the full reimbursement of C-sections has allocated funds to the medicalisation of birth.

Finally, compensation of treatments associated with chronic conditions resulting in complications, is insufficient.[54]

Limitations with regard to purchasing services in the private sector

In case women opt for delivery in a private hospital, the costs are tenfold those at a public hospital. A survey found that the costs of full maternity packages at large private city level hospitals (Beijing and Shanghai) with prenatal care and vaginal delivery were above 40,000 Yuan.

FIGURE 11. CHARGES WITH DIFFERENT LEVELS OF HEALTH FACILITIES, SHANGHAI AND BEIJING, 2018 (RMB)



Source: Pacific Prime, 2018[55]

Note: Acronyms stand for Peking Union Hospital International Department; Beijing New Century Women and Children's Hospital; Beijing HarmoniCare; Beijing Oasis International Hospital; American-Sino Shanghai Beijing Amcare; Shanghai East International Medical Center; Shanghai United Family Hospital; Beijing United Family Hospital.

In the case of delivery at private hospitals, financial protection can be ensured by other strategic purchasing instruments. In case of essential services with quality, such as C-sections, the price rationality should be assessed, and studies could be conducted with a view to regulating private hospital policies related to essential maternal medical services. When services are not essential, so-called high-end services, high OOPs do not necessarily mean low financial protection of women.

In conclusion, all women have access to a basic health package in public health services in China, which includes delivery at a hospital usually at county level. However, according to You et al (2016) 60% of the cost of deliveries in China were paid out of pocket (city in Zhejiang 2014). Migrant

[54] https://bmjopen.bmj.com/content/7/12/e018893#ref-16

[55] http://pacificprime.cn/blog/shanghai-beijing-maternity-costs-2018/

women, rural women and women whose employer does not contribute to the social insurance maternity scheme are disproportionally affected by payment out of their pockets. Some of the explanations may be:

- Women who do not have normal delivery in low tier public hospitals, face additional hospitalization costs that are not covered by health insurance reimbursement fee caps.
- Rural women, the self-employed and unemployed have added limitations in the reimbursement of outpatient health care and hospital services in the city.
- The majority of women migrants often need to return to their places of origin to benefit from adequate maternal care, which implied additional transport costs.
- In many cases, actual delivery expenses are more than the amount covered by maternity insurances or subsidies. C-sections procedures are more expensive and involve longer stays in hospitals, and often exceed amounts of reimbursement. Outstanding amounts fall under normal medical insurance subject to a percentage of co-payment. Attention should be given particularly to situations where C-sections are medically necessary. C-sections for medically indicated reasons (such as imminent asphyxia) are a prevalent problem in low and middle income countries where many are not done or done too late due to lack of money, causing added maternal and infant mortality or morbidity.
- Risk factors associated with birth are increasing. They require additional medical inputs, higher duration of stay in hospital and additional medical specializations not fully covered separately by any insurance or subsidies, so a large portion of the additional burden falls on women and their families.
- For some low income groups, additional costs represent catastrophic healthcare expenditures.

For the reasons above, the main recommendation provided by specialists has been to further consolidate the existing schemes and their risk pooling levels as well as equalising the benefit packages between resident and employee medical benefits (providing better coverage).

It should be noted that there is currently no uniform legal framework for maternal health care in China, contrary to the existence of national regulations for other social security benefits such an old-age pensions, unemployment or employment injury. The existence of a consolidated reference legal framework for both schemes that provide clarity on the list of items covered, by social health insurance could substantially guarantee higher levels of protection and reduce OOPs for urban non-employed and self-employed people as well as rural women.

A review of the reimbursement levels of maternal care, in line with the effective care seeking behaviour and needs of women today, taking into consideration improvements in medical technology, life habits and emerging health conditions, and the aspirations of women and emerging risks would further improve their financial protection in case of maternal health care.

Conclusion

There are still too many maternal and infant deaths during birth in the world, from preventable complications. OOPs borne directly by women at the point of delivery of care, before, during and after childbirth, influence women's access to health care and therefore health outcomes. The application of cost sharing arrangements introduces barriers for women to access pre-natal care, intrapartum care or post-natal care. As a consequence, access to care is delayed and reduced, impacting preventable causes of maternal morbidity and mortality. Renouncing preventive health care compromises early detection of problems, preparation of birth and later care. This may result in sub-standard or incomplete treatments. It can affect the later good physiological and cognitive development of the infant and generate additional costs for health care due to mother health complications.

Although the existence of co-payments is still a financial barrier to accessing maternal care in lower and middle income countries, OOPs are practically non-existent in the European Union in case of maternal care. Moreover, in this region, most countries have a relatively comprehensive package including the coverage of C-sections and hospitalisation during complications. Only two countries have co-payments for maternal health care but additional measures limit the incidence of co-payments on lower wealth quintiles of the population.

Even when a country meets international standards by offering access of pregnant women to a basic package of services that does not require cost sharing, the effective protection of women over time requires that national legislations and practices adapt to the actual health seeking behaviour of women, and new risks associated with maternity. This note has identified international experiences in Europe, Asia and Africa concerning maternal care packages and their financing. China has reduced inter country geographical differences in MMR, but overall MMR is still relatively high and new risks emerge associated with chronic diseases. There are reduced OOPs in overall health expenditure due to government and health finance but there are also growing OOPs per capita. Finally there are significant individual disparities between women in different locations and forms of employment when accessing maternal care.

In order to improve coverage, China could consider reviewing the existing maternal care package in line with WHO medical guidelines and international recommendations. Secondly, it would be important to ensure that the financial incentives from health care purchasing strategies are aligned with those guidelines (i.e. fees received by doctors and facilities for delivery). Finally it could consider establishing a consolidated maternal health benefit package to improve equity, by considering the opportunity of a first national regulation concerning maternal health protection. This would assist in guaranteeing across the country the requirement that there should be no fees at the point of use of an extended package of medically required maternal health services. To assist the legal work, it would be necessary to revise the national maternal health care package purchasing policy in a way that is consistent with financial feasibility and sustainability of the national health insurance schemes.

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ANNEX - Co-payments for parts of maternal benefit package

	Pre-natal visits (incl. imagery)	Normal delivery (midwife or doctor)	Pharma-ceutical	Hospita-lization (incl. C-section)	Post-natal	Other issues co-payments
Austria	No	No	No	No	No	
Belgium	Yes, dependent on income	No in public ward	Yes	No in public ward	Yes	Co-payments depend on insured income
Bulgaria	No	No	No	No	No	Exemption for pregnant women up to 45 days after birth
Croatia	No	Yes	Yes	Yes	No	
Czech Republic	No	No	Yes	No	No	Some medicines require co-payment.
Denmark	No	No	No	No	No	Free maternal medical benefits at point of service
Estonia	No	No	No	No	No	
Finland	No	No (at municipal health care services)	Yes	Yes	No	Medical checks at maternity and child health care centres during and after pregnancy are free of charge.
France	No	No	No	No	No	None. 100% exemption of all costs for pregnant women.
Germany	No	No (midwife assistance)	Yes	No	No	Cost sharing limited to 2% of annual earnings, 10% of each prescription up to 10 Euro for health care user.
Greece	No	No	No	No	No	
Hungary	No	No	No	No	No	
Ireland	No	No	No	No	No	
Italy	No	No	No	No	No	Pregnant women or individuals on low income, are exempted from these user fees or

						pay reduced fees. Fees determined by regions.
Netherlands	No	No	No	No	No	Maternity care exempted from deductibles
Norway	No	No	No	No	No	
Poland	No	No	No	No	No	
Portugal	No	No	Yes	Yes	No	National health service covers 100% except for hospitalization and medicine, but exemptions for lower income groups apply
Romania	No	No	No	No	No	Exemptions for maternal care
Spain	No	No	No	No	No	No cost sharing
Sweden	No	No	Yes	Yes	No	Free maternity services, except hospitalization. Health care user's charge may be reduced according to an income test
Switzerland	No	No	No	No	No	None. No cost sharing for maternal care.
United Kingdom	No	No	No (pregnant women exempted from prescription charges)	No	No	Tax funded in kind service takes full charge.

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