Demand Side Financing for Reproductive and Child Health Services in India

Currently, reproductive and child health services in India are tax financed and provided through supply side financing mechanisms. Some of the limitations of supply side financing are the inability to target the poor, lack of user choice, and the absence of linkages between provider payments and performance. Hence, there is a need to develop innovative financing mechanisms, which are able to target scarce resources at those who cannot afford to pay. One option is demand side financing. Demand side subsidies are not only better at targeting subsidies to the poor, but by linking subsidies with output, also provide the right incentives for efficiency. This paper discusses the concept of demand side financing and recommends piloting of a competitive voucher scheme as a mechanism for RCH services in India.

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The reproductive and child health programme (RCH), as it has progressed in India over the past five decades has gone through several phases of ideological and strategic change. It started with the introduction of population policies with the aim of reducing the size of population, changed various approaches from the camp approach to the cafeteria approach for controlling/reducing fertility and finally, under the influence of the Budapest and Cairo conferences, saw itself transformed into the present RCH programme. The major components of the programme include the prevention and management of unwanted pregnancy, services to promote safe motherhood including emergency obstetric care, services to promote child survival including essential newborn care, prevention and treatment of respiratory tract infections (RTIs) and sexually transmitted diseases (STDs), establishment of an effective referral system, reproductive services for adolescent health, sexuality, gender information, education and counselling.

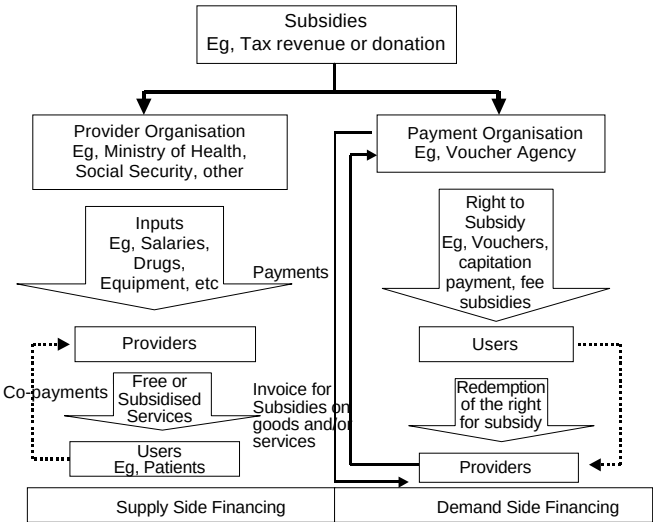
The RCH programme is implemented through the district health care system, which consists of sub-centres, dispensaries, primary health care centres (PHCs), community health centres (CHCs), and the district hospital. Over the years, a massive personnel and public health infrastructure was created consisting of about 1,37,000 sub-centres, 28,000 dispensaries, 23,000 PHCs, 3,500 urban family welfare facilities, 3,000 CHCs, and an additional 12,000 secondary and tertiary hospitals [Ministry of health and family welfare, Government of India, 2000]. But in spite of this large infrastructure, effective and efficient management of RCH services has been hampered by several financial,[1] policy and management constraints leading to provision of services that are inefficient, inequitable and of poor quality [Mavalankar 2002; World Bank 2001].

Although India has made significant strides in reducing maternal and child mortality, lot more needs to be done. India is still one of the few countries with the highest maternal and child mortality [National Family Health Survey (NFHS, 2000)]. Similarly, lot more needs to be done with respect to variation between and within states in India. For example, significant variation is observed between states with respect to antenatal care (ANC) coverage ie, there are districts with full ANC coverage below 5 per cent (districts of Bihar, Uttar Pradesh, Madhya Pradesh and Assam) to others with more than 80 per cent (districts of Kerala, Tamil Nadu, Karnataka). Although the infant mortality rate (IMR) in India is 64 per 1,000 live births, Kerala has IMR of 10 per 1,000 live births whereas Orissa, Madhya Pradesh and Uttar Pradesh have more than 80 per 1,000 live births (SRS 2003). The same holds true for other indicators including the maternal mortality rate. Such variation is also observed between urban and rural areas; and between scheduled tribes and the scheduled caste population compared to other groups. Using the example of institutional deliveries, it is observed that among the richest 20 per cent of the population in India, 65 per cent of deliveries take place in institutions, while among the poorest 20 per cent, only less than 10 per cent are institutional deliveries [Mahal et al 2001].

Hence the present situation with respect to RCH services in India is unsatisfactory. A major policy concern is the need to develop financing mechanisms, which are able to target the scarce resources to those who cannot afford to pay. The challenge is to explore innovative ways by which government subsidies could be better targeted at those who cannot afford to pay, improve equity and efficiency of services, provide choice of providers and improve responsiveness and quality of care. These results are possible if the approach promotes competition, is able to involve the private sector, is in line with government thinking and the preferences of patients, and moves away from input-based funding towards output/performance based funding [Bhatia et al 2004].

One such innovative approach is demand side financing, and a number of countries have recently started experimenting with it. This paper discusses the concept of demand side financing and recommends introducing competitive voucher schemes as a demand side financing strategy for certain RCH services in India. The paper is structured as follows: the next section discusses the current supply-side financing approach in India and brings out its limitations. The concept of demand side financing is discussed in Section II as an approach that may address some of the limitations of supply-side financing. The

Figure 1: Supply vs Demand Side Financing



Source: Sandiford et al (2004).

case for introducing competitive voucher schemes as a demand side financing strategy for RCH services is presented in Section III along with discussion on implementational issues. Finally, the paper ends with some concluding remarks.

I
Supply Side Financing

In India healthcare is financed through general taxation and provided through the government healthcare system. Traditionally in this approach, the funding is for inputs based on capital and recurrent costs. The current tax financed healthcare system in India has its own strengths in providing universal health care services "free" at the point of delivery to all its citizens. In addition, it has the ability to provide comprehensive services. In fact in many states (e g, Andhra Pradesh, Karnataka, and Kerala), this approach has been effective over a period of time.

However, supply side financing strategy has its own limitations in terms of efficiency and equity. Currently, the government is directly involved in provision of health services by employing a huge army of staff, and owning equipment and buildings. This results in huge financial investment giving little flexibility to move resources. Both allocative and technical inefficiency are commonly observed in supply side financing. For example, as most of the budget goes towards the payment of salaries[2] (70 per cent to 90 per cent), there is hardly any money left for purchase of drugs or maintenance of buildings and equipment. Similarly, governments being monopolistic providers, there is no competition, hardly any choice to the patients resulting in services of poor quality and leading to inefficiencies. In addition, supply side financing can result in inequalities in terms of access and utilisation of health services including health outcomes across socio-economic groups. The main reason being that supply side financing is poor in targeting government subsidies, i e, the poor benefit less from public subsidies. A benefit-incidence study [Mahal et al 2001] showed that the poorest 20 per cent receive only 10 per cent of public subsidies on curative care in comparison to the richest 20 per cent who receive more than 30 per cent of subsidies, i e, the rich benefit more than the poor. It is not surprising that in the current system the educated and the rich with influence on the system are better able to capture public services.

II
Demand Side Financing

Given the limitations of supply side financing strategy on the one hand to target poor population who need the services and on the other, the limited impact on improvement of health outcomes, a number of countries have recently started experimenting with innovating "demand side" financing strategies. This approach involves channelling a part of government subsidy for health services directly to households allowing them to purchase health services themselves or through an agency relationship. Demand side financing transfers the purchasing power to beneficiaries for purchase of goods and services [Pearson 2001]. Thus money follows the empowered beneficiaries who are able to vote with their feet.

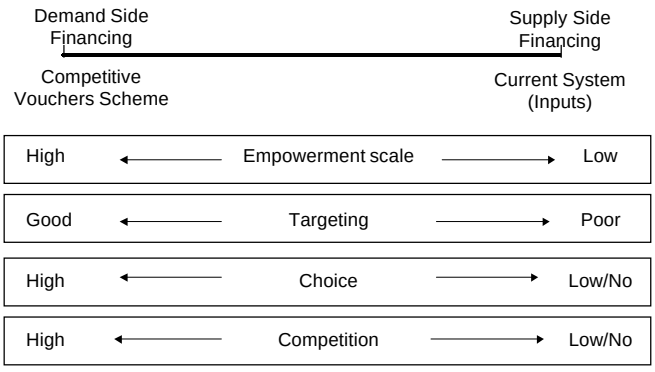
The basic idea behind demand side financing in health is that subsidising demand among the poor for specific health services of known cost-effectiveness, whilst allowing a competitive market for its provision, may be more beneficial than using the same resources to subsidise supply [Sandiford et al 2004]. By introducing market mechanism, this approach alters the incentives for health providers, resulting in increased efficiency,[3] improved service quality and responsiveness thereby providing value for money service. For example, the quantity of funding received by the provider depends upon the outputs produced. In addition, by being able to better target government subsidies[4] to the very poor, it contributes to promoting equity. Demand side financing schemes enable governments to purchase outputs rather than inputs and offer choice of providers to beneficiaries. Choice creates incentives to lower prices and/or raise quality. The key-defining feature of a demand side subsidy is a direct link between the intended beneficiary, the subsidy and the desired output, be that access, utilisation or even some form of health outcome.

According to Bradford (1999) quoted in Ensor (2003), the four characteristics of demand side financing are: ability to target, the choice to users, provider competition and upper limit on payment. Based on these characteristics, an attempt has been made to categorise commonly used financing mechanisms (see the table). It can be observed from the table that current financing strategy performs poorly on all these indicators. Similarly, incentives and vouchers have limited impact on user choice and provider competition. Out of pocket payments do not

Table: Characteristics of Various Financing Strategies

Characteristics	Current Strategy	Incentives for Good Behaviour	Out of Pocket Payments	Health Insurance	Voucher Scheme	Competitive Voucher Scheme
Money follows patient	×	×	√	√	√	√
Targeting	×	√	-	√	√	√
User choice	×	×	√	depends on the design	×	√
Provider competition	×	×	√	depends on the design	×	√
Defined package of service with upper limit on payment	×	√	-	√	√	√

Figure 2: Line of Continuum: From Supply to Demand Side Financing



Source: Bhatia et al (2004).

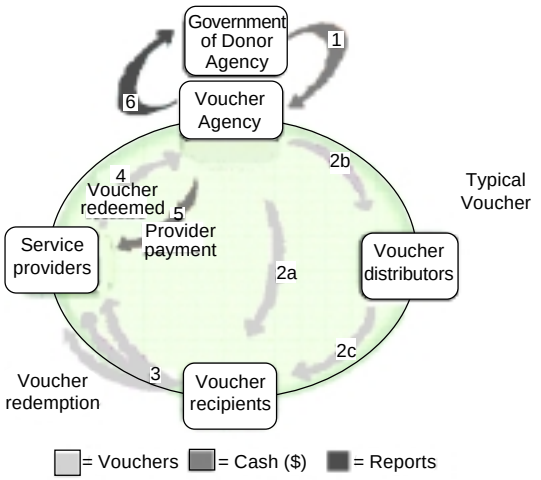
have an upper limit to spending. Therefore, compulsory health insurance schemes[5] (depending upon the design) and competitive voucher schemes appear to qualify as demand side financing mechanisms. Figure 2 presents the line of continuum moving away from current financing strategy to competitive voucher scheme.

III
Competitive Voucher Scheme

In general, making a choice between supply and demand side subsidies will often boil down to whether or not, the expected benefits of increased targeting, raised productivity/service utilisation, improved quality and equity of a demand side subsidy scheme will outweigh the generally higher overhead costs. We expect this will be the case especially for those RCH services, which on the one hand are underutilised by poor/disadvantaged groups and on the other have large externality linked to them.

Subsequently, policy-makers will have to choose between the different demand side options. As incentive based approaches influence the demand side of the market and have certain features of demand side financing, these are commonly categorised as demand side financing. However, they only influence the consumer side of the equation and have no impact on the provider behaviour whatsoever. The typical characteristic of any demand side financing mechanism, i e, "money following the patient" does not occur in an incentive based approach and may be excluded. Out of pocket payments, private insurance and user charges all have characteristics of demand side financing. However, out of pocket payments have their own limitations in terms of equity and in case of RCH services, which have public good characteristics, it may be difficult to charge for some of these services especially for the poor population. Given that our concern is reaching the very poor, out of pocket payments as an option too can be excluded. Although health insurance and community financing schemes are examples of demand side financing, these get excluded as it is commonly observed that the majority of health insurance and community-financing schemes generally exclude RCH services from their coverage in India [Bhatia et al 2004]. Hence, one potential demand side financing mechanism that policy-makers in India may wish to seriously consider is the competitive voucher scheme.

Figure 3: A Competitive Scheme



Source: Sandiford et al (2004).

It is not surprising to note recent interest in the use of vouchers in a number of countries particularly in social sectors like education and health. This trend of using voucher schemes as a demand side financing approach has been on the rise recently, especially in the health sector. For example, encouraged by its success with the education voucher scheme for girls, Bangladesh is keen to introduce vouchers in health specifically to reduce maternal mortality [Islam 2003]. Similarly, Tanzania has introduced voucher schemes for treated mosquito nets [Mushi et al 2003]; and Nicaragua has introduced a voucher scheme for treatment of STI for sex workers [Gorter et al 2004]. The detailed review of international experiences[6] on competitive voucher schemes is beyond the scope of the present paper but how a typical competitive voucher scheme works is shown in Figure 3.

As described by Sandiford et al (2004), for voucher schemes distributing public subsidies the process begins with the transfer of funds to a voucher agency (1 in Figure 3). Vouchers are then produced by a voucher agency and distributed to a target population, either by the agency itself (2a) or to third party organisations (2b) who in turn distribute them to sections of the target population with which they have particularly close links (2c). The voucher is taken by the recipient to a health service provider of his or her choice (3) and exchanged for goods or services (or used as part payment for them).

Health service providers can be clinics, informal practitioners, hospitals, laboratories or other diagnostic services, pharmacies, community care service providers, health promoters, ambulances or other transport service providers, vendors of prostheses and so on. The service providers return the vouchers to the voucher agency (4), along with any other information that it might require, which then pays the providers a sum agreed in advance for each of the vouchers returned (5). The voucher agency reports the programme outputs and outcomes back to the government or donor providing the subsidies.

Application of competitive voucher theory and principles in India: When a new concept is experimented in a new environment, the first concern is its application to the local context. As far as the RCH programme is concerned, the government would like to reach out to some of the vulnerable groups and special groups, whose utilisation will improve the health indicators such as maternal mortality rate, infant mortality rate and child mortality rate. These groups include tribal population, rural landless peasants,

slum dwellers, street youth, single migrants and commercial sex workers.

Selection of providers: The basic concept of the competitive voucher scheme is competition, which means that there are multiple providers for a particular health service package. However, given that 70 per cent of the population lives in rural and tribal areas, where there are hardly any qualified RCH providers, we need to design and implement a voucher scheme that would still ensure quality RCH services in the absence of competition in some areas. For this, the voucher administration agency has to play a crucial educational and monitoring role. The voucher users have to be educated about the quality providers even if they are not qualified providers. The agency has to keep a strict vigil on the providers to ensure that quality RCH services are provided. This is possible because the power to enlist and de-list the provider is in the hands of the agency. In the rural and tribal context, the voucher administration agency may have to enlist less qualified providers such as trained birth attendants (TBAs), auxiliary nurse midwives (ANMs) and trained nurses. The agency has to ensure that these providers are providing scientific and hygienic RCH services.

Selection of service package: The second principle of the competitive voucher scheme is targeting the right services. The RCH programme has a wide range of service packages such as maternal and child health services, family planning services, and reproductive health services. Each package may have several services components. For example, the maternal and child health service package has the service components of antenatal care, intra-natal care, post-natal care, immunisation and so on. All these services may not be delivered efficiently and effectively through the mechanism of competitive voucher scheme. To decide the service component that needs to be included in the service package of the competitive voucher scheme, one needs to decide the type of outcome expected from the RCH programme. For example, the RCH programme is concerned with reducing maternal mortality. One of the main reasons for high maternal mortality is the low proportion of institutional deliveries (30 per cent) in the country. The competitive voucher scheme may target this service component of the RCH programme. To increase institutional deliveries, the agency may have to provide incentive vouchers to TBAs for referring high-risk cases for institutional deliveries. In some places, transport is a problem to reach the maternity home on time for delivery. Here transport vouchers have to be provided to owners of any mode of transportation in the village such as an agricultural tractor. Finally, the right kind of providers of institutional deliveries have to be identified and enlisted for providing institutional delivery services.

Selection of service users: Apart from targeting the programme package, the competitive voucher scheme has to target the user population correctly. It will not be economical to distribute the vouchers to the whole population. Many in the population may have access to good health services and they need not be targeted with the competitive voucher scheme. For example, in Kerala, where more than 90 per cent of deliveries already take place in institutions, they need not be targeted in the competitive voucher scheme. On the other hand, in states like Orissa and Bihar, where the number of institutional deliveries are much lower than the national average of 30 per cent, a competitive voucher scheme will help to increase the proportion of institutional deliveries, thereby reducing maternal mortality. Even here, all need not be targeted but the BPL segment of the population may be targeted to achieve lower maternal mortality rate. Further, the competitive voucher scheme is very useful to some of the vulnerable groups like commercial sex workers or street youth, who may not go to the government health facilities. Though these populations may not be very large but their health problems are very acute. A competitive voucher scheme will enable them to go to a provider with whom they are comfortable in sharing their reproductive health problems.

All the three factors (provider, service component and user) should be considered together to decide on using the competitive voucher scheme in the RCH programme. The competitive voucher scheme shall be used judiciously, so that it targets the right user, and the service package, so that maximum results can be achieved in terms of health outcome.

Administering Competitive Voucher Scheme for RCH Programmes in India

The main challenge of successfully implementing the scheme depends on the administration of the competitive voucher scheme. It has to be implemented at the district level and hence a district administrative machinery is necessary to implement the scheme. The issues are many. Can we use the present district health administration to manage the scheme? Do they have the managerial capacity? Do we create a new administrative machinery for the scheme? Who will print the vouchers? How do you decide the price of voucher for each RCH service component? Who will administer the scheme at the sub-district level? Who will identify the right user and distribute the right voucher to the user at the village level? What should be the redemption mechanism for the provider to get the reimbursement for the services provided? Being a new scheme that has never been experimented in India and with few examples from other countries, the above questions are daunting. Some attempts are made to answer the above-mentioned issues.

The present district health administration has its plate full and it does not have the managerial capacity to venture into this new scheme. The current district administrative structure itself is not flexible enough to manage the scheme. The government has formed district RCH societies but they are currently working at low key with very little financial powers. Since they are in the formative stage, it may be possible to strengthen these societies with additional input in terms of human resource and management capacity. The advantage of the society is that though it is a part of the government, it is not governed by the bureaucracy of the government. Further, it has representation from the community, NGO and the private sector. It is worth considering developing the district RCH societies to take over the administration of the competitive voucher scheme. Already, under the sector investment programme (SIP) supported by the European Commission, these societies are strengthened into district health authorities. The competitive voucher scheme may be experimented in one of these districts.

The second option would be to make use of some of the large NGOs which have the capacity to manage the scheme. There are three NGOs in the country, who have already some experience with some form of voucher scheme in the country. They include Seva Mandir in Rajasthan working among the tribal population in Udaipur district. Seva Mandir uses the vouchers for delivering maternal and child health services. In Kolkata, the Child in Need

Institute (CINI) was using a competitive referral voucher for the slum population for two years, which was working successfully. After the funding for the subsidy came to an end, it is not working well. Janani in Bihar is creating a network of RCH providers through the concept of franchising. This can also be used for introducing the voucher scheme. Therefore, it is possible to use these large NGOs to administer the competitive voucher scheme [Bhatia et al 2004].

At the grassroot level, it is important to distribute the vouchers to the target population and educate them, so that they use it judiciously. Here again, different options exist. Panchayati raj institutions (PRI) can be involved in the scheme. Already, the constitutional amendment makes provision for the PRIs to manage healthcare at the village level. There are community-based organisations like self-help groups (SHG) in many villages, who can play a major role in distributing the vouchers to the target population.

From the above, it is clear that there are different options available to introduce a competitive voucher scheme in the RCH programme. But all these options need to be experimented with before implementing them on a large scale in the country. Therefore, it is suggested that some pilot projects at selected districts may be set-up using different models and should be documented to learn lessons and prepare a plan of action for using the competitive voucher scheme as a powerful vehicle to achieve the RCH goals.

Any innovative strategy is less likely to succeed unless it is acceptable to both the public and policy-makers. Given its commitment to achieving its 10th plan targets and beyond (regarding the reduction of maternal and infant mortality rates), government of India is keen to experiment with different financing and delivery reforms in health care and the RCH programme. It appears that the use of vouchers and involvement of the private sector appears to be in line with the government of India's policy and preferences of general public in India. The national population policy (2000) mentions the use of coupons/ vouchers, "create a national network consisting of public, private and NGO centres, identified by a common logo, for delivering RCH services free to any client. The provider will be compensated for the service provided, on the basis of a coupon, duly counter-signed by the beneficiary, and paid for by a system to be devised. The compensation will be identical to providers across all sectors. The end-user will choose the providers of the service. A group of management experts will devise checks and balances to prevent misuse". With respect to involvement of private providers in delivery of RCH services, the document mentions, "at district and sub-district levels, explore the possibility of accrediting recognised private practitioners for a year at a time, and assign to each a satellite population, not exceeding 5,000, for whom they may provide RCH services. The private practitioners would be compensated for the services rendered through designated agencies. Renewal of contracts after one year may be guided by client satisfaction. This will serve as an incentive to expand the coverage and outreach of high quality health care" [National Population Policy 2000]. Given the potential to involve private sector in such schemes, it is likely that the general public too will be in favour of competitive voucher schemes. Although government services are "supposed" to be free at the point of use, majority including the poor, prefer to opt for the private sector. A number of studies show that the private sector is an important source of health care in many developing countries including India [Bhat 1999; Mahal et al, 2001; Peters et al 2002; World Bank 2001; Preker and Harding 2000].

Limitations of Demand Side Financing

Although demand side financing has its advantages, this approach also has number of limitations (see the box). Some of these are over-servicing because of the direct link between outputs and the receipt of subsidies, combined with moral hazard and supplier-induced demand. Also, assuring that services are actually provided may be problematic. Cream skimming, where providers actively seek to avoid providing care to groups that require more services than others – is yet another problem that can be associated with demand side subsidies. The disadvantage of higher transaction and administrative costs because of the need to quantify outputs must not be forgotten. These costs can be substantial, especially in voucher schemes, where they include costs of voucher production, contracting providers and monitoring their performance, distributing vouchers, reimbursing providers, and establishing systems to avoid abuse of the voucher scheme. Last but not the least, care should be taken to ensure that while encouraging private sector in service provision, any demand side financing scheme does not have negative impact on the public health delivery system.

Conclusion

Demand side financing strategies may be one option for policy-makers in India to counter the limitations of the current supply-side financed RCH programme. Of the various demand side financing mechanisms, competitive voucher schemes hold a great potential in terms of targeting pro poor population with respect to RCH services. However, competitive voucher schemes could have high transaction costs and so before taking a policy decision, government of India will need to consider whether any additional administrative costs can be outweighed by the ability of a voucher scheme to deliver the subsidies and their benefits more efficiently or effectively.

It is therefore recommended that government of India set up a pilot for a competitive voucher scheme to deliver the RCH service package of maternal and child health care and

Box: Advantages and Disadvantages of Demand Side Financing

Advantages	Disadvantages
Potential to target subsidies	May have high administrative costs
Payment linked with performance	Complex to set up
Stimulates provider competition	Difficulties in targeting
Greater choice to users	Leakages/abuse
Consumer empowerment	Opportunity for collusive behaviour
Encourages innovation	Moral hazard and cream-skimming
Promotes public private partnerships	Weakening the public sector
Uses surplus capacity in the private sector	Issues around capacities, skills and systems.
Improves equity, efficiency, choice, responsiveness and quality of services.	

the family planning services in India. Since all the RCH programmes are administered from the district level, it is recommended that the pilot is set-up at a district level and targets the below poverty line (BPL) population in the district. The purpose of the pilot is to experiment and test the competitive voucher scheme as a demand side financing initiative to stimulate demand for under-utilised RCH services, in one district for BPL households.

Given the strengths of the current financing strategy for health care in India, it should be noted that this paper is not recommending alternatives to the current financing strategy. Instead this paper aims to complement the current financing strategy in addressing some of its concerns, particularly in terms of targeting government subsidies and providing access to marginalised population groups, who for various reasons are unable to access RCH services within the government sector. EPW

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Notes

[We gratefully acknowledge the institutional cooperation component of the European Commission and government of India for funding a study on "Demand Side Financing for Reproductive and Child Health Services in India". We also acknowledge the useful discussions we had with other team members during the course of the study namely Ramesh Durvasula, Elias Mossialos and Alistair McGuire. Finally, we also thank Gopi Gopalakrishnan, Janani in Bihar; Neelima Khetan, SEVA Mandir in Rajasthan and Papu CINI in Kolkata for facilitating our visit to these organisations, and giving us time and inputs for developing the case-studies.]

1 India is one of the few countries that spend one of the lowest GDP per capita from public sector on health (0.9 per cent).
2 There is little incentive for staff to improve their performance or be responsive to their patients as salary is paid at the end of the month irrespective of the outputs produced.
3 Besides promoting competition, which can improve efficiency, the focus of demand side financing shifts from inputs to outputs, which further provide incentives to improve efficiency and promote accountability.
4 Numbers of studies have also shown that it's the rich who benefit most from the public health sector. Hence an important policy concern for Government of India is how to channel/target pubic subsidies to poor populations in order to improve their access to health care.
5 If health insurance schemes are voluntary (like the community financing schemes), it is likely that the scheme may not sustain as a result of adverse selection because those who are healthy may opt out of the scheme leaving the sick (mostly the poor) in the scheme as the pooled funds have limited capacity to absorb such risks.
6 Kindly refer to Gorter (2003) for detailed review of competitive voucher schemes.

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