Do competitive voucher schemes improve the provision of health care to underserved and/or vulnerable population groups? Experiences from Nicaragua, India and Africa

Voucher distribution to adolescents

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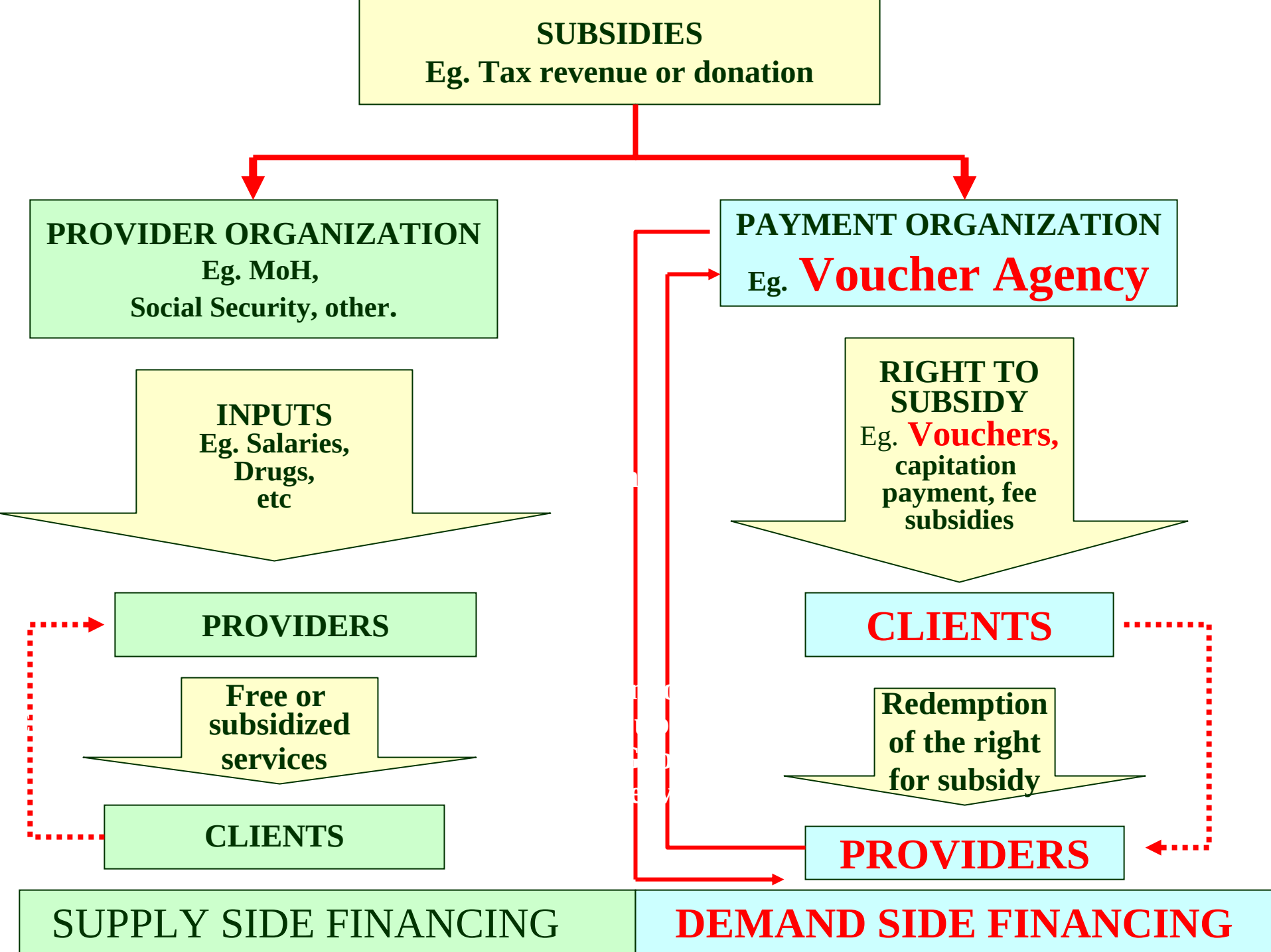
Outline of presentation

- Demand-side versus supply-side subsidies
- What are competitive voucher schemes
- Potential strengths of vouchers in developing countries
- History of voucher schemes in health
- Experiences from Nicaragua, Asia and Africa
- Discussion: do vouchers improve provision of health care to underserved and/or vulnerable population groups?


SUBSIDIES
Eg. Tax revenue or donation
PROVIDER ORGANIZATION
Eg. MoH,
Social Security, other.
PAYMENT ORGANIZATION
Eg. Voucher Agency
INPUTS
Eg. Salaries,
Drugs,
etc
RIGHT TO SUBSIDY
Eg. Vouchers, capitation payment, fee subsidies
PROVIDERS
CLIENTS
Free or subsidized services
Redemption of the right for subsidy
CLIENTS
PROVIDERS
SUPPLY SIDE FINANCING
DEMAND SIDE FINANCING

Demand Side Subsidies
Consumer-led versus Provider-led

CONSUMER-LED

- **The subsidy is transferred to the client, either in advance of service provision, or post-hoc as a refund**

PROVIDER-LED

- **The subsidy is given to the provider based on a contractual arrangement with the funding agent**

Examples of consumer-led subsidy schemes

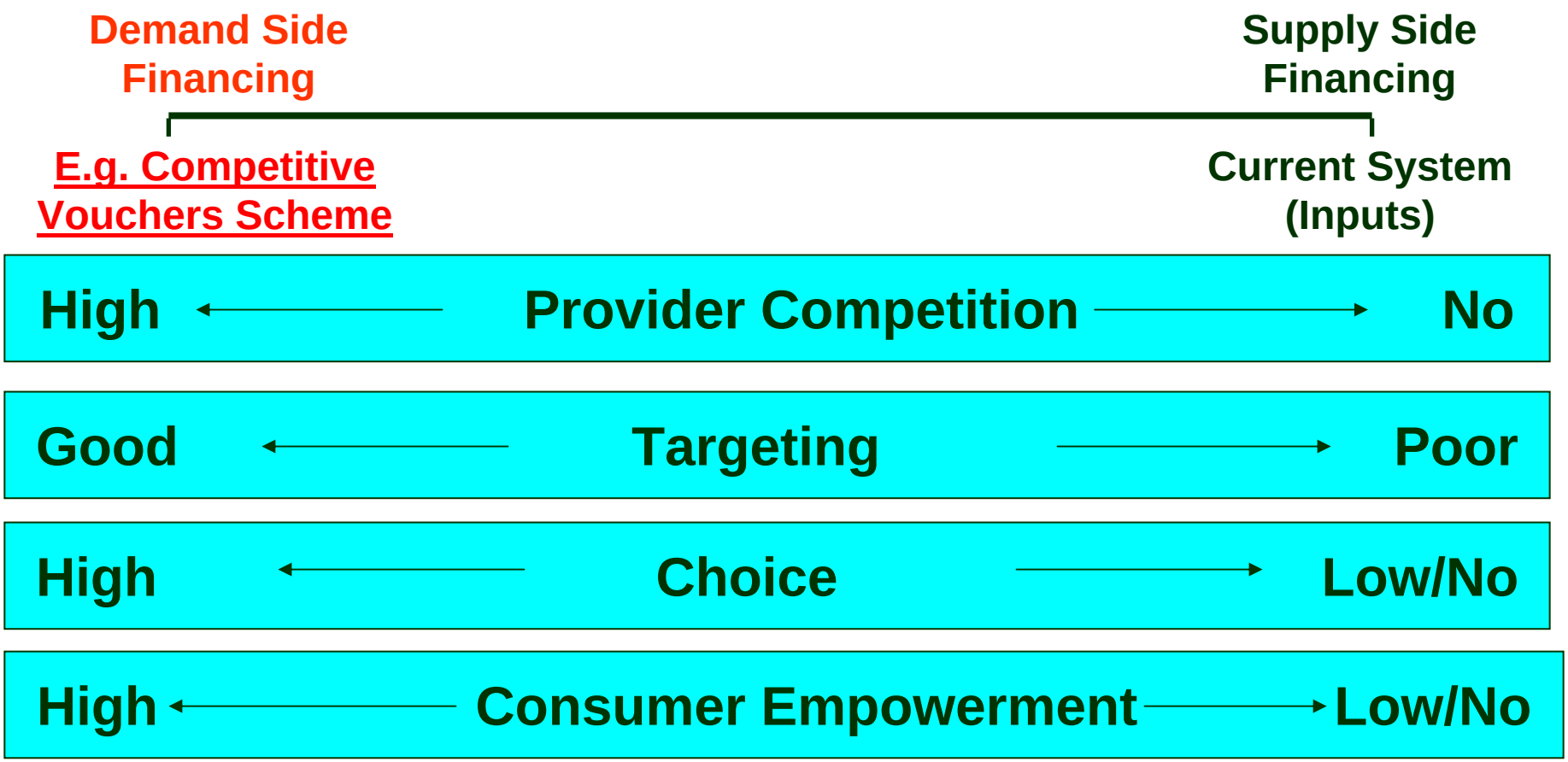
TRANSFERRED BEFORE SERVICE PROVISION

- Cash transfer payments
- Contributions to family medical savings schemes
- Vouchers
  - Competitive
  - Non-competitive

TRANSFERRED AFTER SERVICE PROVISION

- Cash refunds
- Conditional cash transfer (incentive based voucher)

Demand side financing
compared to
Supply side financing



What is a voucher

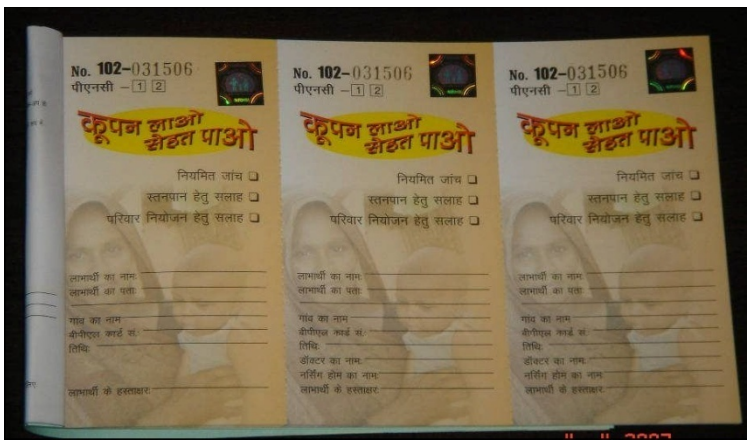
A document which can be exchanged for defined goods or medical services as a token of payment

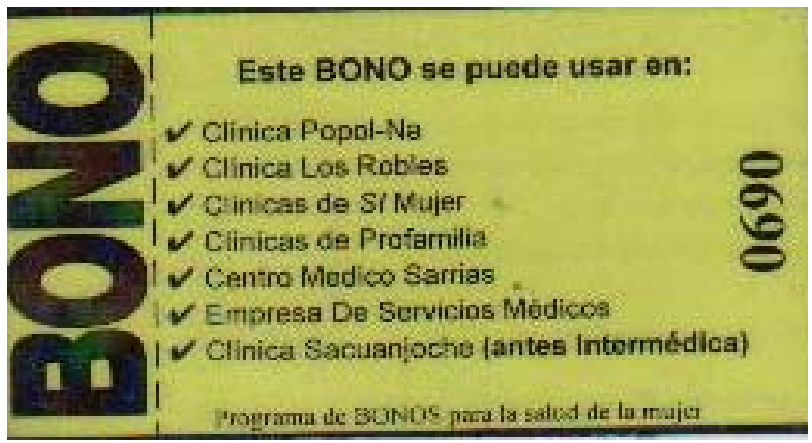
OR

"Tied cash

(as opposed to liquid cash)"

Some examples of vouchers





Examples of vouchers in other sectors

- Education (US, Europe, LA, Netherlands)
- Employment (Argentina, US, Netherlands)
- Training (LA, Kenya, Zimbabwe, USA)
- Elderly care (Spain)
- Housing (USA)
- Pension (Bolivia)
- Welfare (UK, USA)

Why use vouchers in health?

- **Market failure to serve certain poor, marginalised and / or vulnerable populations,**
- **even if services are associated with positive externalities (treatment also benefit others), eg:**
  - **Infectious diseases**
    - **e.g. STI-HIV-AIDS services for sex workers**
  - **Family planning**
  - **Safe motherhood services**

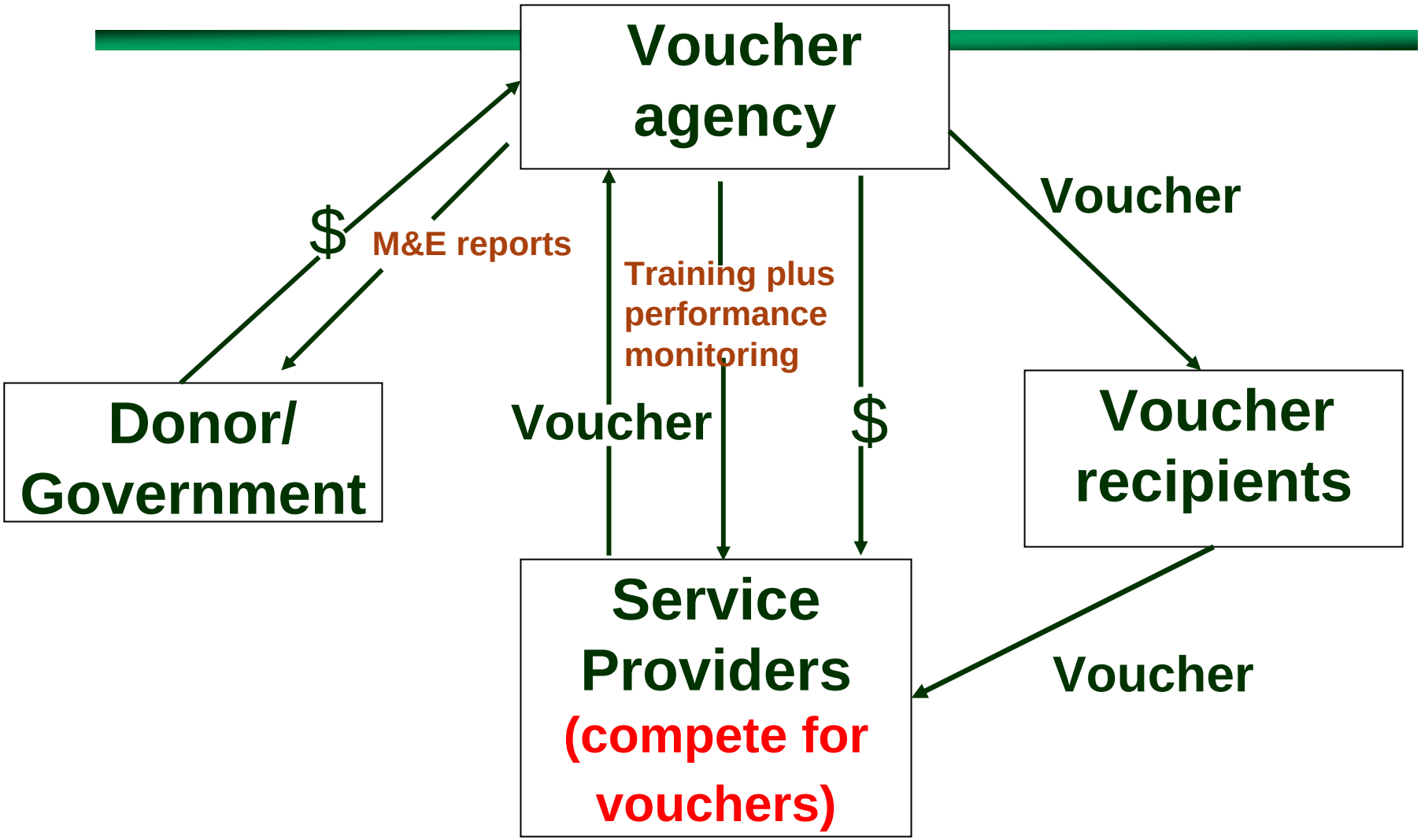
Some examples of non-competitive vouchers

- Increasing access to mother and child care for poor to public health services (Cambodia, China)
- Increasing access to reproductive health care for poor to an NGO clinic (Dominican Republic)
- Creating a needle exchange program for intravenous drug users at pharmacies (China, Vietnam)
- Ensuring partner referral of patients with STIs (Central African Republic)
- Research eg. in breast screening (USA)

History of competitive vouchers

- Taiwan: one of the earliest, access to family planning('64-'69)
- USA: Migrant farmers programs to fill gaps of access to primary health care (since 1983)
- Pilots of several voucher programs in the nineties
  - Kenya, adolescent sexual and reproductive health ('98-2000)
  - India, primary health care for slum dwellers ('99)
  - Indonesia, Safe Motherhood '98-2004 (private midwifes Java)
  - Tanzania: Discount for Insecticide Treated Nets ('97-'99)
  - Nicaragua: voucher trial (1995 to 1998) with sex workers was successful, development of more schemes

Competitive voucher scheme



Strengths of competitive vouchers

- Targeting of population sub-groups
- Encourage use of specific services
- Can increase operating efficiency
- Can improve service standards / quality
- Payment for services actually provided
  - Possible to pay only incremental cost
- Facilitates monitoring and evaluation

Targeting

Of identifiable groups which are vulnerable and often underserved:

- **Marginalised groups**
  - **drug-addicts, sex workers, street youth**
- **Groups who fear stigmatization**
  - **MSM, or people with TB, Leprosy, AIDS**
- **Vulnerable groups, e.g. because of age, gender, behaviour or poverty**
  - **Adolescents, young people**
  - **Clients of sex workers (incl. mobile groups, e.g. truck drivers)**
  - **Poor pregnant women in rural areas**

Empower the consumer and thereby encourage use

When demand is limited by barriers to access (cost, lack of knowledge, stigma..)

- **Vouchers inform about services and guide users to where services can be obtained**
- **Remove cost barriers (incl. eg transport costs)**
- **Power of choice increases client satisfaction**
  - **Encourages use, positive experience leads to repeat use**
  - **‘Worth of mouth’ recommendation to others**

Nicaraguan schemes target those most at risk or underserved & encourage use

- **STI-HIV-AIDS prevention & treatment**
  - sex workers and their clients
  - men who have sex with men
  - Glue-sniffing youth
- **Sexual & Reproductive Health care**
  - poor adolescents and young people
- **Cervical Cancer screening and treatment**
  - older women in rural and remote areas

Other schemes target and encourage use of safe motherhood services

Providing safe motherhood through vouchers to reduce maternal mortality (MDG5):

- **Kenya: public, private, NGO & mission hospitals (poor women)**
- **India / Gujarat: private gynaecologists (poor women from remote areas)**
- **India / Uttar Pradesh: private nursing homes (poor women)**

New schemes:

- **Bangladesh: public, private & NGO providers (poor women)**
- **Cambodia: public & private providers (poor women)**

Vouchers can increase efficiency & improve service standards

- **Increased utilization of private sector resources (non-profit and for-profit)**
- **Reduced input costs**
- **Competition between participating providers (private, NGO, faith based, public) :**
  - **Reduced price**
  - **Increased service quality**
  - **Increased clients satisfaction**

When do vouchers increase efficiency / standards most?

- Providers with excess capacity; increased utilization gives economies of scale
- Strong competition between providers (more than one provider available)
- Where contracts specify 'best practice' service package & staff required to undergo training
- only cost-effective services are provided
- medical supplies are procured centrally
- vouchers are distributed by third parties

Vouchers facilitate monitoring and evaluation

Mechanics of vouchers incorporate:

- **Regular monitoring of provider performance against contract specifications**
  - **Interviews with redeemers, 'mystery patients'**
  - **Medical record review**
  - **Tracking redemption rates / follow-up consultations**
- **Providers report to voucher agency**

Program impact assessed by tracking voucher use and linking changes to health outcomes

Schemes to be discussed and their financing

- **Migrant Farmer scheme - US Government**
- **Nicaragua – many different donors**
- **India Gujarat – State government**
- **Uganda – KfW (German Development Bank) and Global Programme on Output-based Aid (WB)**
- **Kenya – KfW**
- **India, Uttar Pradesh, Agra scheme – USAID**
- **Cambodia – Government and KfW**
- **[*Bangladesh – Government (TA by donors)*]**

Migrant Farmer – US
"Born out of necessity" in 1983

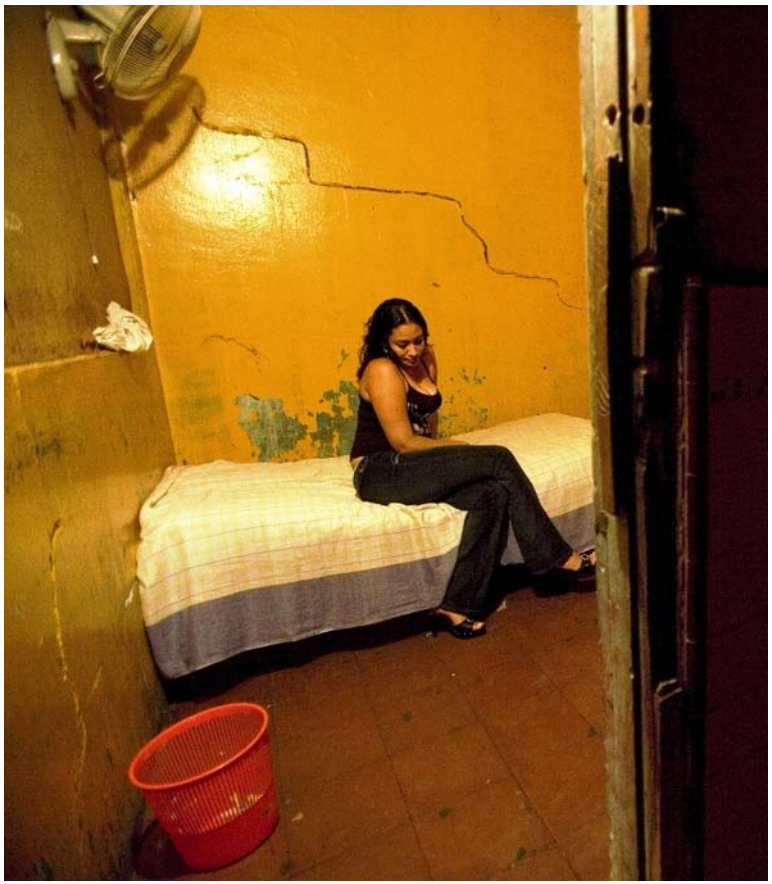
- Where number of migrant patients is too low for full scale migrant health clinic
- Primary health care for underserved at public, NGO or private providers contracted in advance
- 21 programs serving over 100,000 migrants
- Some benefits mentioned by staff:
  - Vouchers "make private providers part of the continuum of care"
  - Private MDs often report great satisfaction working with migrants
  - Migrants learn to negotiate the healthcare system
  - Encourages creativity as staff networks with public and private providers and negotiates prices

Migrant Farmer Programme Outreach Workers Illinois

Nicaraguan HIV voucher scheme started 1995

- To detain the development of a HIV epidemic
- Financed by many donors (UK, NL, US, NGOs, GF), Government no role, NGO is voucher agency
- Reaches highly stigmatised populations:
  - Sex workers, clients, MSM, glue-sniffing young people
- Mostly NGO clinics, some private / public providers in more remote areas
- STI services, HIV testing, over 20,000 consultations
- Difficulties maintaining of funding
- Experiences used to write the Guide to Competitive Vouchers in Health

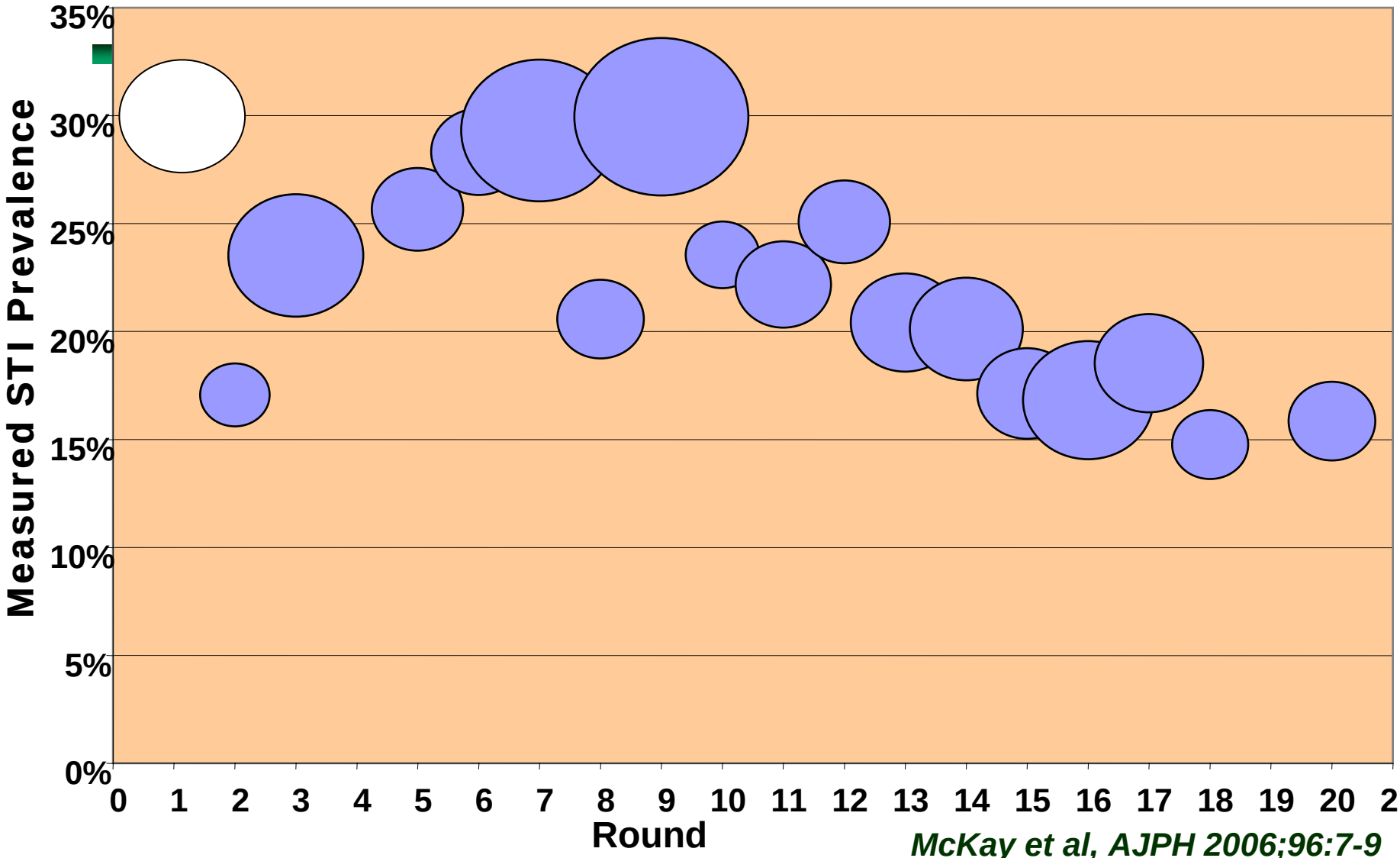
Stigmatised populations



Sex worker in brothel, Managua

Glue-sniffing youth, market Managua

Impact of treatment rounds on STI prevalence in sex workers voucher scheme in Nicaragua (long periods between treatment rounds – high bounce back of STIs)



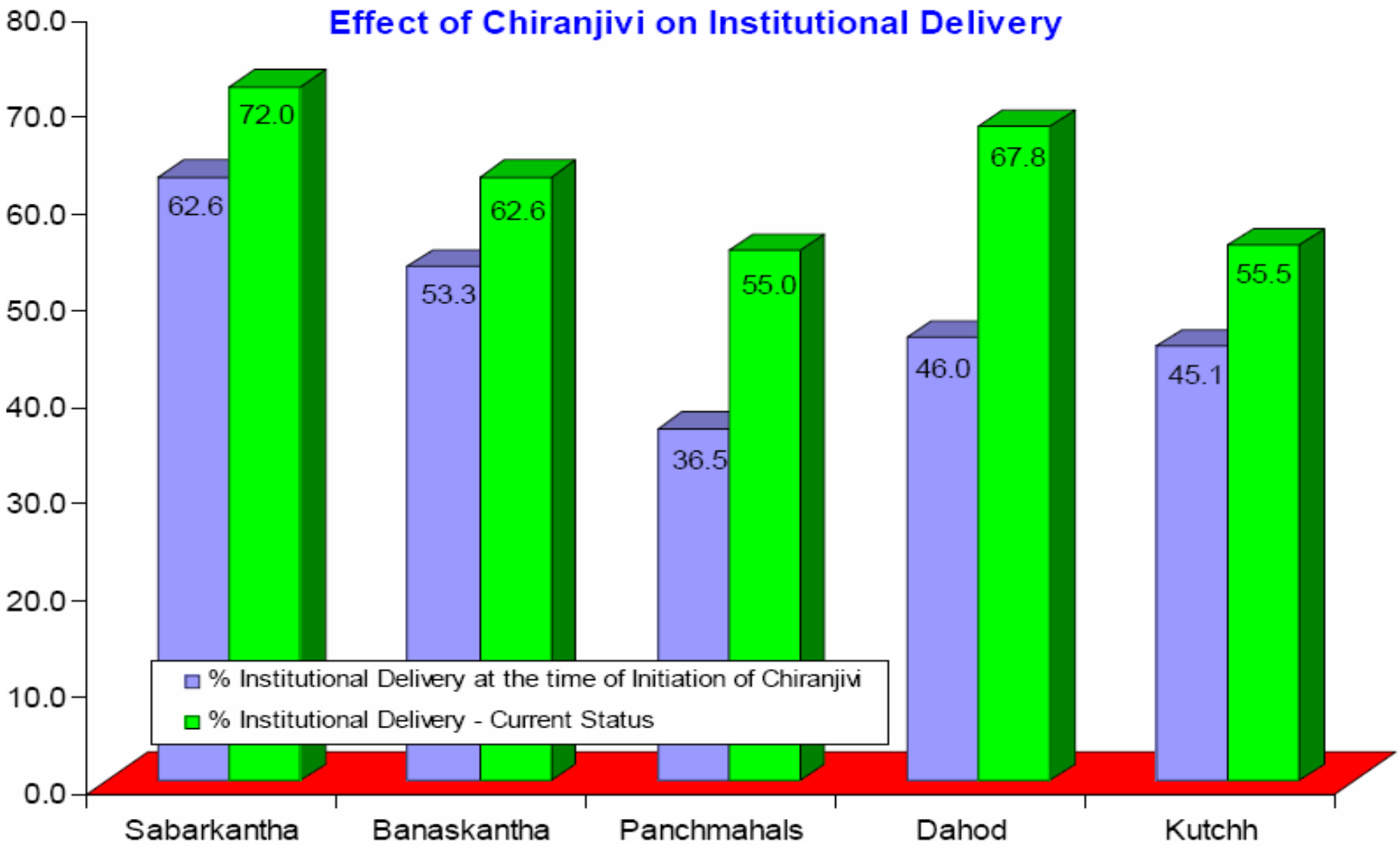
McKay et al, AJPH 2006;96:7-9

Gujarat scheme (2005) "Chiranjeevi Yojana" (long life)

- To reduce maternal mortality among poor
- Developed by state Government (high level commitment) after many failed attempts to reduce maternal mortality through supply-side
- Facilitated by technical assistance Academic Institutions, NGOs and GTZ
- Over 800 private obstetricians in rural areas
- Voucher is the BPL Card (Below Poverty Line)
- Started in 5 pilot districts

Impact of voucher pilot Gujarat

Over 40,000 Institutional Deliveries in 5 pilot districts, Jan 2006 – March 2007



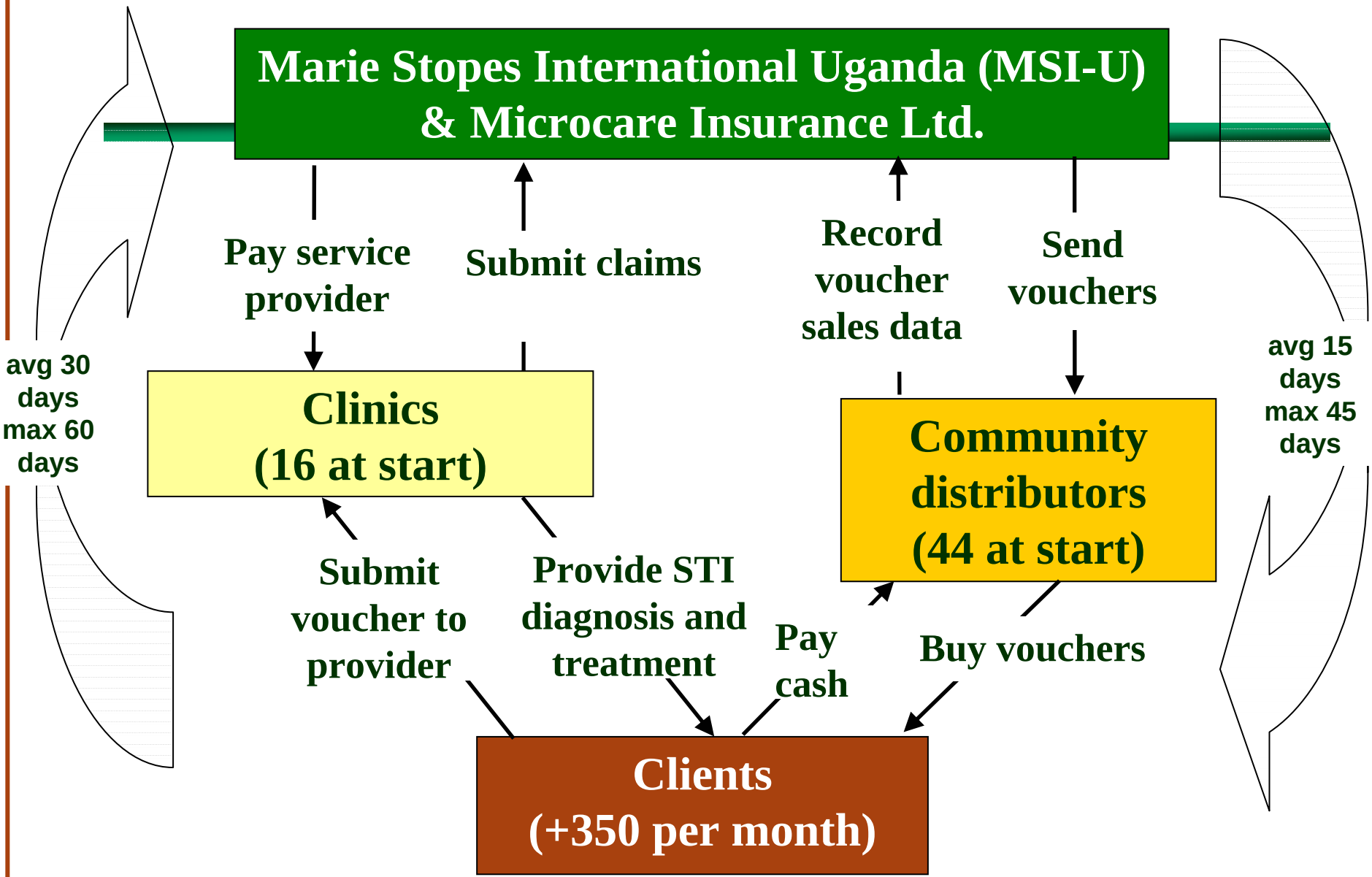
Dr. A Singh, Voucher Workshop April 2007, Gurgaon, India

Cont. Gujarat scheme

- Since 2007 state-wide
- Over 160,000 deliveries
- Coverage of deliveries increased 27% to 48%
- Expected deaths 642, real deaths 32
- Costs: 3.6 % of total state health budget
- More efficient to harness private MDs than wait for supply side improvements in public sector
- Development of health markets in rural areas

Uganda vouchers (2006-2010) Output-Based Aid (OBA)

- To treat high burden of STIs general population
- Unattended pregnancies in poor women
- Output-based contract with private clinics
  - Negotiated fee-for-service
  - Clinics must satisfy accreditation requirements
  - Clinics must comply with service delivery guidelines
- Vouchers are sold at a highly subsidized price
- Vouchers marketed with health information to clients with STI complaints


Marie Stopes International Uganda (MSI-U)
& Microcare Insurance Ltd.
Pay service provider
Submit claims
Record voucher sales data
Send vouchers
avg 30 days max 60 days
avg 15 days max 45 days
Clinics (16 at start)
Community distributors (44 at start)
Submit voucher to provider
Provide STI diagnosis and treatment
Pay cash
Buy vouchers
Clients (+350 per month)

Evaluation of OBA in Uganda

- **Population surveys of 2600 respondents before and 16 months after launch (analysis will be available late 2008**
- **Clinic-based records review to determine utilization and cost-effectiveness**
  - **In first 18 months over 17,000 STI patients**
  - **Clinic review July 2007 found 200% increase in utilization at contracted clinics**
  - **7% of adults in pilot districts had recent syphilis infection**
- **Cost-effectiveness will be assessed July 2008**

Future of Uganda OBA

- **STI vouchers will continue**
- **Program is expanding to include Safe Deliveries (June 2008). Program will cover additional districts with goal of delivering 100,000 babies a year for the next 3.5 years**
- **Program serves as model for Ministry of Health as it considers mechanisms for effective service delivery and possible social insurance**

Kenya voucher scheme June 2006-KfW

- Poor in 3 rural districts, 2 urban slums Nairobi
- To increase access to safe motherhood, family planning and gender violence recovery
- Public, private, faith-based and NGO providers
- Voucher agency is PriceWaterhouseCoopers
- Vouchers are sold at highly subsidized prices
- Over 40,000 vouchers sold (specifically safe motherhood vouchers successful, other much less)
- Extension planned with 10 million Euro
- Seen as catalyst for a National Social Health Insurance Scheme

Uttar Pradesh, India
Agra voucher scheme (2007)

- UP: highest Maternal Mortality of India
- Targets BPL families
- Voucher management: CMO-ANM-NGOs
- Village Health Worker distributes vouchers
- 3 districts: private provider, 1 district: public
- Expected to attend 6,500 pregnant women, over 3,000 for FP and 8,000 STIs in 2 years

The first voucher baby Rachna

Cambodia 2007 and 2009

- **Successful non-competitive voucher scheme in Kampong Cham province (Feb 2007):**
  - **Targeting poor pregnant women**
  - **Reduced financial barrier to deliver at facility**
- **New competitive scheme financed by KfW**
  - **Kampong Cham and two other provinces**
  - **Safe deliveries, abortions, family planning for poor**
  - **Reduce maternal mortality, development of regulatory framework (accreditation, quality assurance) for public and private health providers**

Some potential drawbacks of vouchers

- High start-up costs
- Set-up is complex (devil is in the detail), needs highly trained staff at start
- Not feasible when cost of services is variable or unpredictable or need for services difficult to verify
- May be susceptible to abuse (black market, collusion between providers and distributors..)
- Program development may take time

However once established easy to run and to scale-up, and costs go down

Lessons from experiences when seem vouchers to be successful?

- Appropriate design, committed stakeholders
- Independent Voucher Management Agency and "non-bureaucratic" management procedures
  - smooth payment of providers
  - non-stigmatising distribution of vouchers
  - able to adapt to new knowledge/circumstances etc
- Tap into private sector resources and engage private providers in serving needy populations with services they were unable to obtain before

Cont.
when seem vouchers to be successful?

- Vouchers address priority needs
- Vouchers address the specific barriers (money, information, stigma, age etc)
- Free service or appropriate price / discount
- Competition (within or for the market)
- Service costs not too variable or unpredictable

When are vouchers considered useful

- **Top 1: to assist populations who are currently underserved and vulnerable to specific health threats or don't receive services with important positive externalities (e.g. STI/HIV services)**
- **Top 2: to change the way health sector financing works and use private sector capacity**
- **Top 3: to set the tone for the introduction of health insurance schemes**

Conclusion

Vouchers are useful for the provision of health care to vulnerable and/or underserved populations

Currently only experience with clearly defined packages of priority services, targeted at underserved populations

After pilot phase in nineties, now larger schemes underway….and impact and cost-effectiveness studies

Great potential in e.g.:

- **Reduction of maternal mortality in poor women**
- **STI services and HIV/AIDS prevention in groups most at risk**
- **Increase of coverage of family planning**