Voucher schemes for sexual and reproductive health services: a Marie Stopes International (MSI) perspective

A large proportion of healthcare in developing countries is delivered outside the public sector. In Pakistan, for example, 80% of total health expenditure is made by individuals making out-of-pocket payments for curative services provided by independent, private health care providers.1 The large scale of the private health sector highlights a number of issues, including shortages of public healthcare facilities in poor rural areas and urban slums and the real or perceived low quality of services that they offer.

The existence of a large private sector in developing countries presents an opportunity to increase access to key health services alongside longer term efforts to build up public sector capacity. However, harnessing the private sector to provide key services to low income groups – and thereby contribute to national health objectives – presents a number of key challenges:

- private providers are usually unregulated by the state in developing countries and the quality of service can often be very low as a result
- the range of services offered may be those which maximise revenue, instead of those which offer the best public health outcome, such as long-term family planning methods, bed-nets and other preventative services
- the services may be priced too expensively for many to access them.

The objective of voucher schemes is to utilise the large but unregulated private sector, by incentivising providers to deliver key health services at greatly improved standards, and to make them affordable.

Footnotes:
1. National Health Survey of Pakistan, Government of Pakistan 1998

“Vouchers: a targeted intervention harnessing new service providers

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### Overview of established MSI voucher schemes: - Kenya, Pakistan and Uganda

**Kenya:**
- established 2005 in three rural districts and two Nairobi slums
- donors: KfW and the Government of Kenya
- includes a family planning voucher for long acting and permanent methods for about US$1.25 and a Safe Motherhood voucher for antenatal care, institutional delivery and postnatal care services for US$2.50
- MSI’s role: the major service provider offering both maternity care and static and outreach family planning services.

**Pakistan:**
- voucher scheme established November 2008 and integrated into a social franchise programme over 18 districts
- one service voucher: for IUD insertion and removal through private providers
- 100 participating private sector providers, with an aim to include 500 by 2012
- MSI’s role: project founder and management agency.

**Uganda:**
- established 2008 and has expanded to 20 districts
- donors: KfW, the Government of Uganda and the World Bank’s Global Partnership for Output Based Aid
- includes HealthyLife vouchers for the treatment of sexually transmitted infections (STIs) and the HealthyBaby vouchers for antenatal care, safe delivery, and postnatal care - the vouchers are sold to women for the equivalent of $1.50
- MSI’s role: management agency.
- 76 HealthyBaby vouchers providers and 27 for STI

**Other countries:**
- new schemes recently established in Viet Nam and Sierra Leone
- MSI plans to open new schemes in Philippines and Ethiopia in 2010/11.

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### Why vouchers?

Voucher schemes have the advantage of being able to target services at specific groups according to geographic, demographic or socio-economic criteria. In doing so the primary beneficiaries are those who need the services most or who have the most difficulty in accessing public health services.

By making the vouchers available to the target group at a heavily subsidised price, the benefit to the voucher user, or client, is not just that the service becomes affordable but that the price becomes fixed. Thus a pregnant woman knows she will not face higher charges in the event of a complicated delivery or caesarean. Similarly, family planning vouchers enable users to choose the method of contraception that suits them rather than the cheapest option.

In competitive voucher schemes where multiple service providers are accredited to participate, the client is able to exercise choice over which provider they visit. By empowering low income clients to choose or reject a service provider in this fashion, a powerful incentive is created for providers to improve the quality of their services in order to attract the most clients. Furthermore, the accreditation process by which providers gain eligibility to participate in the scheme, provides additional opportunities to ensure that requisite quality criteria are met.
Implementing vouchers in practice

Voucher schemes comprise five core components:

1) the funder (either government, donor or a combination of both)
2) the voucher management agency
3) voucher distributors
4) clients (or target beneficiaries)
5) service providers

Evidence of MSI voucher scheme impact

Kenya:

- 60,000 babies safely delivered between June 2006 and October 2008
- 12,000 long acting family planning services provided over the same period including a tenfold increase in female sterilisation procedures in one participating district
- significantly increased demand for contraceptive implants (effective protection against unplanned pregnancy for four years)
- quality of healthcare improved: 89% of for-profit, 85% of public, and 67% of non-profit service providers used voucher revenue to improve infrastructure, buy equipment or drugs and supplies, hire new staff, or create patient amenities
- overall programme costs were $135 per safe delivery, including obstetric emergency cases.

Uganda (awaiting full impact assessment in 2010):

- 8,286 babies delivered as of April 2010 and voucher sales increasing rapidly
- service providers already observed to have made significant investments in improving quality of services
- an external evaluation (University of California) demonstrated significant falls in the prevalence of syphilis and gonorrhoea in household surveys conducted before and during the intervention.

Despite the advantages, donor support for voucher schemes has been criticised from some quarters for diverting funds that could be used to invest in public health services. It is true that in most developing countries, the public health sector suffers from chronic under-investment and remedying this will remain a key priority for international development efforts. However, private sector providers are likely to remain a significant source of healthcare for the poor for the foreseeable future, so it is important that their potential is utilised and quality and safety is improved. Voucher schemes enable governments and private providers to work together which develops the state’s capacity for contracting, regulating and monitoring non-state health providers and hence improving the quality of care being offered. In this sense, voucher schemes can play an important role in health system strengthening.

“Voucher schemes have the advantage of being able to target services at specific groups”
Key lessons learned through MSI’s experience of voucher schemes

- get the right number of providers relative to the size of the programme – each provider needs to win enough revenue from the scheme to incentivise participation
- public providers can also participate in voucher schemes if central government permits clinics to keep their own ‘voucher revenue’ for local investment rather than see it returned to central coffers
- accrediting a good variety of providers is beneficial (public, private and NGO) to give clients real choice
- the voucher management role is critical – ensure this position is appointed to a competent agency
- marketing vouchers to the target beneficiaries is an important component, although word of mouth has a powerful demand-creation effect
- ensure swift and fair payment systems to ensure providers are paid for the work they do
- on-going quality assurance is needed to maintain and improve the quality of care being given to clients
- monitoring of services is essential to maintain standards and prevent fraud.

Voucher schemes work well for services that are:

- high in demand for easily diagnosed and defined conditions (e.g. pregnancy)
- relatively expensive, to justify administration costs of management agency
- currently failing to reach certain groups or communities.