

## What can vouchers do for Universal Health Coverage?

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### Key take-aways

- Vouchers for health promote equity, financial protection and quality of care
- Vouchers are relevant in both fledgling and well-established UHC systems
- Well-targeted vouchers can help both SHI and input-based UHC systems avoid common pitfalls

Vouchers often get a bad rep: they probably make you think of junk mail, hawkers on street corners, and the odd 25%-off haircut. To be honest, vouchers also have a fairly low profile in global health. Because health vouchers have mostly been used to stimulate demand for priority health services among underserved groups, they have been labelled as a narrow policy tool, a distraction from the ambitious goal of Universal Health Coverage.

A health voucher gives its recipient the right to access a clearly defined health service (or health services package) at quality-assured health facilities for free. That same voucher then enables the health provider to claim payment for the services they provided to the voucher-holding client. Vouchers are the only health financing tool that subsidises demand while also channelling investment to the supply side. 2-for-1! Now there's vouchers for you!

Far from being a distraction from Universal Health Coverage (UHC), this policy brief shows that vouchers further the core principles of UHC, while also having the ability to solve common problems experienced by even the most well-established UHC systems.

### Vouchers and the three principles of Universal Health Coverage

The aim of Universal Health Coverage is for “all people to use the quality health services they need without suffering financial hardship paying for them”<sup>i</sup>. This can be translated into three core principles: **equity** (getting ‘all people’ the ‘health services they need’), **financial protection** (‘without suffering financial hardship’) and **quality of care** (‘quality health services’)<sup>ii</sup>.

#### Equity

Equity is the cornerstone of Universal Health Coverage<sup>iii</sup>. Because voucher services are either free or heavily subsidised, and are usually targeted to populations with specific access problems,

they can help guarantee that effective coverage does not vary by income<sup>iv</sup>.

This is important for Universal Health Coverage, even in systems where the whole population is theoretically entitled to free services. For one, vouchers help ensure that entitlements to free services are enforced: voucher distribution involves an opportunity to inform the client about his/her rights, the transaction is more closely monitored, and the provider gets paid for serving voucher-holding clients. One of the key objectives of [Armenia's](#)<sup>1</sup>

<sup>1</sup> For all voucher programmes referenced in the text, see Annex A for further information

voucher programme is in fact to eliminate informal provider payments in the private sector<sup>v</sup>.

Secondly, vouchers can strengthen access for vulnerable groups through health education, as voucher recipients are sensitised to the importance of accessing a given service and informed about where to access it during voucher distribution.

Thirdly, the incentive to reorganise services to attract voucher clients may also serve to improve demand for services, particularly for the poorest. Voucher clients often report that the voucher brings them status, and that they are better treated than they otherwise would be.

Finally, vouchers for health services can easily be combined with other incentives to address the opportunity cost of accessing services: a review by Grainger et al (2013) found that nearly half of the programmes reviewed made a contribution to the cost of transport<sup>vi</sup>.

### Financial protection

Vouchers enable vulnerable populations to access priority health services without having to pay at the point of care, thereby protecting them from catastrophic health expenditure in the absence of social health insurance or tax-financed services.

Furthermore, vouchers make an important contribution to financial protection by including private clinics in the list of eligible facilities, particularly in contexts of high utilisation of private services by the poor (e.g. Pakistan).

Finally, vouchers contribute to financial protection insofar as they help planners, providers and clients move towards a social health insurance (SHI) system<sup>vii</sup>. Many of the skills and institutions introduced and/or strengthened by voucher programmes are also required in order to manage social health insurance. For example, [Kenya's](#) National Hospital Insurance Fund used their experience

with vouchers to inspire several improvements to their own insurance system. They are working to define insurance benefits more clearly, monitor contract adherence, and include private providers in accreditation and quality assurance systems<sup>viii</sup>.

### Quality of care

Vouchers can incentivise providers to improve quality of care<sup>ix</sup>. Where providers have autonomy to reinvest voucher payments in quality improvements, re-organisation of services, and/or the addition of new services (e.g. caesarean sections, or long term family planning), there is evidence that services are better tailored to the needs of the target group (better hygiene, privacy, more female staff and so on), and perceived quality improves. In the case of the [Kenya](#) Reproductive Health Output-Based Approach programme, for example, participating facilities chose to reinvest voucher revenue to repair and improve buildings, buy equipment, medicines, and supplies, improve 24/7 attendance and improve transport options<sup>x</sup>.

Vouchers also make important contributions to quality by establishing processes for accreditation and quality assurance, which are highly compatible with health financing strategies aimed at the supply-side, such as 'contracting out'. In some cases, voucher programmes strengthen existing quality improvement programmes. For example, in [Yemen](#), any facility certified by the pre-existing Quality Improvement Programme is automatically qualified to enrol in the voucher programme, and a 'quality bonus' might be introduced for enrolled voucher facilities in future, with higher reimbursement rates for higher quality services.

### How universal can vouchers really be?

Despite growing evidence for vouchers' impressive impact in terms of equity, financial protection and quality of care, they remain for now a specific tool to enable underserved groups to access priority services. However the WHO's 'cube' frames progress towards UHC in terms of the share of people, services and costs covered, with a focus on **growing** these three dimensions as far as possible<sup>xi</sup>. Given this understanding of UHC, how important can vouchers' contribution to UHC really be?

The first point to remember is that vouchers do not have to be targeted. For example, all families were eligible for the wildly successful family planning voucher programmes in [Korea and Taiwan](#) in the 60s-90s. Even among targeted voucher programmes, some are being operated on a huge scale: the [Chiranjeevi Yohana scheme](#) in Gujarat, India, which is targeted to the poor, is a case in point. Vouchers don't have to be targeted to specific services either: [vouchers for migrant farm workers in the US](#) cover all types of services with a maximum reimbursement level<sup>xii</sup>. This sort of voucher programme illustrates very clearly how vouchers and insurance are actually on the same spectrum, as noted by Gorter et al (2013)<sup>xiii</sup>. A voucher scheme in [Tanzania](#) is located even further along that spectrum: vouchers distributed to pregnant women entitle the mother and her baby to full health insurance during the baby's infancy, while the rest of the family gains entitlement to partial health insurance<sup>xiv</sup>.

However, most voucher schemes do target particular groups, and/or provide entitlement to only a few services. Far from being contradictory to UHC, targeting vouchers both in terms of services and population groups could actually help even well-established UHC systems avoid common pitfalls.

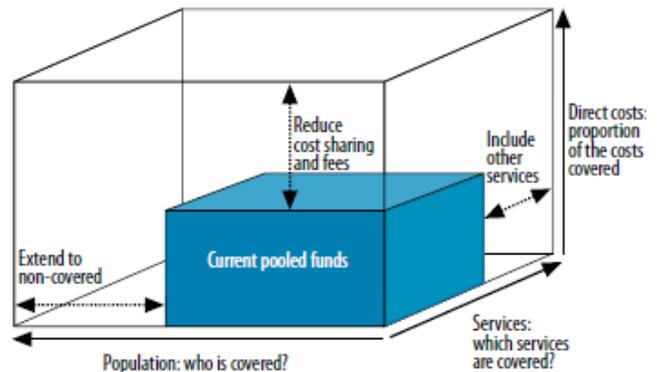


Figure 1: WHO's Universal Health Coverage 'Cube'

### Pitfall 1: Social Health Insurance can emphasise curative care at the expense of public health and preventative care

Because the first aim of Social Health Insurance is to prevent catastrophic health expenditure, some fledgling insurance schemes start by covering expensive inpatient services only, excluding outpatient, primary and preventative services from the benefit package (e.g. India, Kenya, Philippines)<sup>xv</sup>. In addition, individuals in any system (whether SHI or input-based) may under-consume public and preventative health care if left to their own devices. This is because some of the risks of not seeking care, such as infecting others, as well as the future costs of illness, are borne by others. In either of those situations, vouchers can serve as a useful addition to the prevailing health financing approach, thereby ensuring that preventive services are appropriately emphasised. Vouchers are often used for preventive services, most notably for family planning, but also for immunisation ([Cambodia](#) and [Armenia](#)), and cervical and breast cancer screening ([Nicaragua, Vietnam](#))<sup>xvi</sup>.



**Pitfall 2: Exclusion of the private sector from coverage in input-based health financing systems**

Vouchers provide a structure to include private sector providers in universal health coverage, thereby increasing the quantity or quality of health services available, and improving equity by breaking down a two-tier system of care. In Australia, for example, vouchers are being discussed as an innovative solution to increase the uptake of services such as diabetic eye and foot care, by giving clients the choice to access care through the private sector.

**Pitfall 3: Health financing strategies aimed at UHC sometimes don't pay enough attention to equity**

Vouchers could be used to reverse inequitable trends in countries that have been building universal coverage from the top down (e.g. Brazil, Kenya, Nigeria<sup>xvii</sup>), assuming that coverage will eventually trickle-down to the poorest<sup>xviii</sup>. This is not a desirable pathway to universal health coverage<sup>xix</sup> and serves to worsen inequitable access to care. Vouchers could begin to reverse this situation by adding health financing subsidies targeted to the poor. As discussed above, even well-established UHC systems could use vouchers to help ensure that effective coverage is truly equitable.

**Figure 2: Voucher designs, Yemen Reproductive Health Voucher Programme**



**An innovative and flexible solution to further Universal Health Coverage**

Vouchers play a key role in furthering Universal Health Coverage because they can be strategically deployed to address shortcomings in equity, quality or financial protection in any health financing system, for a wide range of health services and target groups, and in combination with any number of incentive payments (on the demand-side) and performance-based financing approaches (on the supply-side). We all know that achieving UHC requires a combination of innovative solutions. Vouchers may be one of the most exciting and flexible ones in the lot.



### List of referenced voucher programmes

Country	Title of voucher scheme	Brief Description
<b>Armenia</b>	Obstetric Care State Certificate Program (OCSC)	Started in 2008. Nationwide. Women in 22 <sup>nd</sup> week of pregnancy receive a certificate (or voucher) when attending ANC providing access to institutional delivery (including C-section and treatment of complications) and guaranteeing no informal payment can be taken.
	Child Health State Certificate (CHSC)	Started in January 2011. Follows the design of the OCSC providing full coverage for paediatric hospital in-patient services including drugs and medical supplies, lab tests and instruments, examinations, specialist consultations, prescribed medical procedures, and hospital ward stays for all children under 7 yrs. Also includes socially vulnerable children 7 – 18 years and any child under 18 needing emergency care.  Providers in both programmes are reimbursed according to the number of services provided using an established rate for that service (i.e. normal delivery, C-section) and according to the facility contract (i.e. different hospitals receive different rates)
<b>Cambodia</b>	Vouchers for Reproductive Health Project	Started in 2011. Financed by the German Development Bank (KfW), the scheme provides access to maternal health care, family planning and abortion services by accredited public and a limited number of private providers in three provinces, targeting poor households. The vouchers are used to extend the reach of the Health Equity Funds (HEF) to lower levels of the health system (health centre level) and as a mechanism to verify that the client actually used the services.
<b>India, Gujarat State</b>	Chiranjeevi Yohana	Started in 2005. State-wide and publicly funded programme through which women in possession of a below-poverty-line (BPL) card can go to an accredited private obstetrician for free institutional delivery. Participating private providers are reimbursed a flat rate per 100 deliveries (including C-sections) by the State government. The model has been adopted wholesale by other states with varying degrees of success.
<b>Kenya</b>	Reproductive Health – Output-Based Approach programme (RH-OBA)	Started in 2005. Financed jointly by the German Development Bank (KfW) and the Government of Kenya, this programme provides access to a package of safe delivery care, long-acting family planning, and gender-based violence recovery services for poor women and their families. It currently works in 2 Nairobi slums and 4 districts and is being expanded.
<b>Nicaragua</b>	3 small schemes for adolescent SRH; STI diagnosis and treatment for commercial sex workers; and cervical cancer screening	These schemes began in the late 1990s and were managed by a local NGO with assistance from donors (DFID, Dutch Government, USAID and others). They contracted with providers in the public, private-for-profit and private not-for-profit sectors to provide free access to targeted groups. Providers were trained to provide services, and then reimbursed according to the voucher claims submitted.

Country	Title of voucher scheme	Brief Description
<b>Taiwan &amp; Korea</b>	In each country the voucher scheme was part of the overall National Family Planning Programmes	Both schemes developed in 1964 with the objective to lower the fertility rate through accelerating the use of family planning, contracting with mostly private providers. After a small pilot in each country, the voucher programmes were quickly scaled nationwide and continued until the mid-1980s when fertility had reached replacement level. Both received varying amounts of donor finance over the years and in Taiwan the scheme began with universal targeting and moved to poverty-based targeting as the fertility rate dropped.
<b>Tanzania</b>		Started in September 2011 and financed by the German Development Bank (KfW), the scheme enrolls (and subsidises) poor pregnant women in a temporary health insurance programme, providing access to a broad package of services. Their family members receive subsidised entry to community health insurance which the mother can then join for a reduced fee once her membership of the insurance scheme expires.
<b>Uganda</b>	Reproductive Health Voucher Programme	Started in 2006 and financed by the German Development Bank (KfW) and the World Bank through GPOBA (after a feasibility study in 2004), and managed by Marie Stopes Uganda. Started providing access to STI treatment and diagnosis through private pharmacies and health care providers and later expanded to safe deliveries. More recently, with finance from USAID, the scheme has widened to include family planning services. National scale-up is currently being planned with the assistance of the World Bank.
<b>United States</b>	Migrant voucher health voucher programmes	Many small, independently managed schemes in different states which provide access to a defined basket of health services. Contracts are made with any available provider in the targeted area and providers are reimbursed a capitated rate per patient per year. There is no physical voucher and eligibility is determined by each management agency's outreach workers.
<b>Vietnam</b>	Voucher scheme	A small scheme run and managed by Pathfinder International in 2009. The scheme provided access to STI services at contracted private providers for commercial sex workers.
<b>Yemen</b>	Yemen Reproductive Health Voucher Programme	Started in November 2012 and financed by the German Development Bank (KfW), this is a 3 year programme providing access to safe delivery services and long-acting family planning in 3 Governorates in Yemen through contracted public and private providers (private midwives, BEmONC and CEmONC levels). The Government of the Republic of Yemen is providing a financial contribution to the reimbursement payments to public providers.

### About the authors

**Laura Sochas** is a health economist. She conducts quantitative analysis and modelling for Evidence for Action, a DFID-funded programme to improve maternal and newborn survival across six countries in Sub-Saharan Africa.

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**Options' Results for Health team** was set up in 2008 and has grown rapidly over the past five years to include the provision of technical advice and management services for results-based financing in health. Areas of expertise include voucher design and programming, cash transfers for health and early childhood nutrition, as well as innovative combined demand-side and supply-side interventions.

The R4H team is currently providing technical assistance and management services to long-term programmes in Malawi, Mozambique, Pakistan and Yemen as well as a growing number of short-term assignments. Clients include the German Development Bank (KfW), the Norwegian Government, World Bank, DFID, and UNFPA as well as international NGOs such as Marie Stopes International and PSI.

**For more information about Options, the R4H team, or the article, please contact Corinne Grainger, at: [c.grainger@options.co.uk](mailto:c.grainger@options.co.uk)**

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