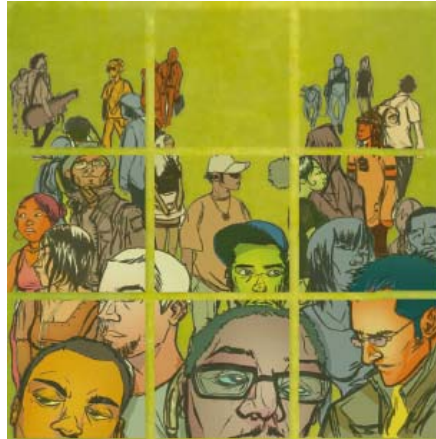


# **Demand Side Financing in Health: How far can it address the issue of low utilization in developing countries?**

**Indrani Gupta, William Joe, Shalini Rudra**

**World Health Report (2010)  
Background Paper, 27**



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# **Demand Side Financing in Health: How far can it address the issue of low utilization in developing countries?**

*World Health Report (2010) Background Paper, No 27*

**Indrani Gupta<sup>1</sup>, William Joe<sup>1</sup>, Shalini Rudra<sup>1</sup>**

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## **1. Introduction**

The concept of Demand Side Financing (DSF) in health originated in response to developing countries' felt need to improve access to and utilization of health services, particularly among the poor. Policymakers in developing countries have come to realize that public health services, interventions and innovations have not yielded the desired health outcomes due to serious issues concerning the efficiency, fairness and quality of the health systems that have been created and maintained through significant tax-based financing. In particular, the utilization and uptake of services has been very low among those who would benefit most from these services, that is to say the poor and vulnerable sections of the population. This is especially true for services such as family planning, maternal and child health, immunization etc.

DSF was therefore seen as a tool that could improve the utilization of under-used services among the needy and under-served populations by placing purchasing power, as well as the choice of provider (where possible), directly in the hands of the recipients. The services considered most relevant in this context were those that qualified as merit goods, and had significant externalities (for example, immunization, maternal and child services, use of bed nets for malaria control).

Though not often stated explicitly, the main argument cited in favour of DSF is that beneficiaries face mainly financial barriers that prevent them from using a particular service or intervention. The financial barrier argument often extends to geographical distance, so that providing either funds for transport or providing transport itself is also seen as a way to overcome barriers to access.

An extensive literature exists and is still evolving from the wide range of country-specific experiences on DSF in the health as well as in the education sectors, which has been the original target of DSF in the world. However, there is still a good deal of confusion with regard to concepts and definitions, especially in the context of the plethora of health coverage schemes operated as community health insurance (CHI) or micro-insurance schemes that often use the same rationale of financial demand constraints among vulnerable populations for providing health coverage. At times it is not clear how best to classify different initiatives and schemes with multiple objectives and complex structures often defy easy classification.

The focus of this paper is twofold: first, based on a global literature review, it examines the definitional issues around DSF and presents a schematic that can be used to classify schemes; second, it attempts to fit selected case studies of health-care interventions in India into the proposed schematic to both test the

template's usefulness and to enable a better understanding of what qualifies as a DSF initiative. Finally, based on a survey of literature on evaluation, the paper presents the main benefits and drawbacks of DSF, and provides some operational insights into where DSF stands as a financing tool for improved health seeking behavior in developing countries. The discussion focuses mostly on reproductive health, but additional examples have also been added, where relevant.

## **2. DSF: A brief overview**

There have been some very comprehensive reviews and evaluations of DSF schemes (see, among others, Ensor 2004a, Handa and Davis 2006, LaGarde, Haines and Palmer 2007, Hatt et al 2010). In this paper it is not our intention to present that kind of overview, but rather to discuss some definitions, examples and findings to set the context for the next section, which will revisit the definitions of DSF from a purely operational perspective.

The global literature contains many examples of DSF, with different terminologies (output-based aid, conditional cash transfer, consumer-led DSF, provider-led DSF) used for slightly differentiated products. The defining characteristic of DSF – what sets it apart from supply side financing – is the direct link between the subsidy, the beneficiary and the objective of the subsidy. DSF can be consumer-led (vouchers, cash transfers, tax rebates) or provider-led (capitation payment, referral vouchers), and can be provided before or after service utilization. This system of output-based remuneration for services rendered in principle can improve efficiency in service delivery through competition (Ensor 2004a, Standing 2004).

The most commonly implemented DSF mechanism is one that uses vouchers, defined here as “a token that can be used in exchange for a restricted range of goods or services. Vouchers tie the receipt of cash to particular goods, provided by particular vendors, at particular times. Health care vouchers are used in exchange for health services (such as medical consultations or laboratory tests) or health care consumables (such as drugs)” (World Bank 2005). Voucher schemes are designed to efficiently target population selected to benefit from the scheme. Health vouchers are seen as instruments that encourage the use of under-consumed services like family planning, treatment of infectious diseases, immunizations, mental health care, and maternal and child health services by subsidizing (fully or partially) health-care costs (Gorter et al 2003).

Another often-mentioned phrase in the literature is Output-based Aid (OBA) which is a combination of consumer-led and provider-led DSF (Brooks and Smith 2001). These are perceived to be development aid strategies that link the delivery of services to targeted performance-related subsidies. The service providers can come from the private or public sector, or from community or non-governmental organizations. All OBA schemes must specify the outputs against which subsidies will be disbursed and consequently can identify the beneficiaries more clearly than traditional input-based schemes. Output-based aid through vouchers is now an important strategy for donors striving to improve the effectiveness of aid (Brooks and Smith 2001). The World Bank has been the most active participant in OBA, and in 2003, along with the United Kingdom's Department for International Development (DFID), it launched the Global Partnership for Output Based Aid (GPOBA).

These are also called “voucher and accreditation”<sup>2</sup> strategies for health services, which emphasize not only incentives for consumers, but attempt to ensure quality services by enforcing performance-based contracts with facilities. Such initiatives have been launched in Bangladesh, India, Kenya, Nicaragua, Taiwan Province of China and Uganda in the developing world. In this context, “competitive voucher” schemes are seen as sharper tools because they allow for competition among providers, rather than allow single-window provider access (Gorter et al 2003).

Other examples of recent initiatives on DSF are Conditional Cash Transfers (CCT) which aim to reduce poverty by making welfare programmes conditional upon the recipients' actions (Handa and Davis 2006, La Garde et al 2007). The government transfers the money only to persons who meet certain criteria, which may include, for example, getting regular screening for cervical cancer or receiving vaccinations (*Janani Suvidha Yojana* in India or Nepal's Safe Delivery Incentive Programme (SDIP)).

Well before the current spate of experiments with vouchers as a key mode of DSF in developing countries, they have been used to encourage vulnerable and special groups to seek medical care in other parts of the world. While one of the first instances of voucher use occurred in the Republic of Korea and in Taiwan Province of China in the 1960s<sup>3</sup>, there have been a number of examples of voucher schemes in developed countries. For example, in Wisconsin, in the United States of America (USA), vouchers were used among migrant Spanish-speaking workers to encourage them to access health care (Slesinger and Ofstead 1996). Meanwhile a study in Minnesota, USA, on the effectiveness of vouchers for breast cancer

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<sup>2</sup> [http://www.popcouncil.org/projects/231\\_EvalVouchAccredRH.asp](http://www.popcouncil.org/projects/231_EvalVouchAccredRH.asp)

<sup>3</sup> KfW Entwicklungsbank, “Interview with Prof. Dr. Malcolm Potts with respect to Output-Based-Aid (OBA) voucher schemes as a means of promoting public health in developing countries.” Available from < [http://www.kfw-entwicklungsbank.de/EN\\_Home/Topics/Health/Interview\\_mit\\_Prof\\_Potts\\_Berkeley.pdf](http://www.kfw-entwicklungsbank.de/EN_Home/Topics/Health/Interview_mit_Prof_Potts_Berkeley.pdf)

screening indicated that vouchers did improve screening rates (Stoner et al 1998). There are many other examples from USA of vouchers being used to better target needy populations in housing, education and health (Varady and Walker 2003, West 1997).

With regard to developing countries, in Nicaragua, vouchers were introduced to tackle high rates of sexually transmitted infections (STI) among sex workers in Managua (Gorter et al 2000). There are additional examples of such schemes in Nicaragua, one for addressing adolescent health and the other for prevention of cervical cancer.<sup>4</sup> In Mexico, poor families received monthly income transfers equivalent to between 20% and 30% of income providing that (among other conditions) pregnant women visited clinics to obtain prenatal care, nutritional supplements and health education (Gertler 2004). In the United Republic of Tanzania, vouchers were used for malaria control, especially among women and children (Mushi et al 2003).

In South Asia, Bangladesh, India and Nepal all have DSF schemes, although the Bangladesh initiatives are relatively larger and more widely discussed. The Government of Bangladesh has launched a DSF scheme in 33 *upazilas* (sub-districts) with vouchers being distributed to pregnant women entitling them to access free antenatal, delivery, emergency referral, and postpartum care services, as well as providing cash stipends for transportation and cash and in-kind incentives for delivering with a qualified health provider. The program also introduces incentives to health-care providers to identify eligible women and provide maternal health services. The objective of the program is to increase the use of skilled birth attendants and to mitigate the financial costs of delivery, as part of Bangladesh's efforts to reach MDG 5 and to achieve a 75% reduction in maternal mortality by 2015 (Hatt et al 2010). The DSF scheme in Nepal is a safe delivery incentive programme (SDIP) where cash is given to the eligible women after delivery at a health facility. Indian DSF schemes will be discussed in more detail in the subsequent sections.

The extremely varied character of DSF schemes (as well as schemes that are generally not labelled DSF but nevertheless have similar characteristics) makes it difficult to engage a cogent discussion on what the merits and demerits of such initiatives are or even to say with any certainty what comprises the set of schemes that can be called DSF. In the next section, we discuss some key definitional issues with DSF

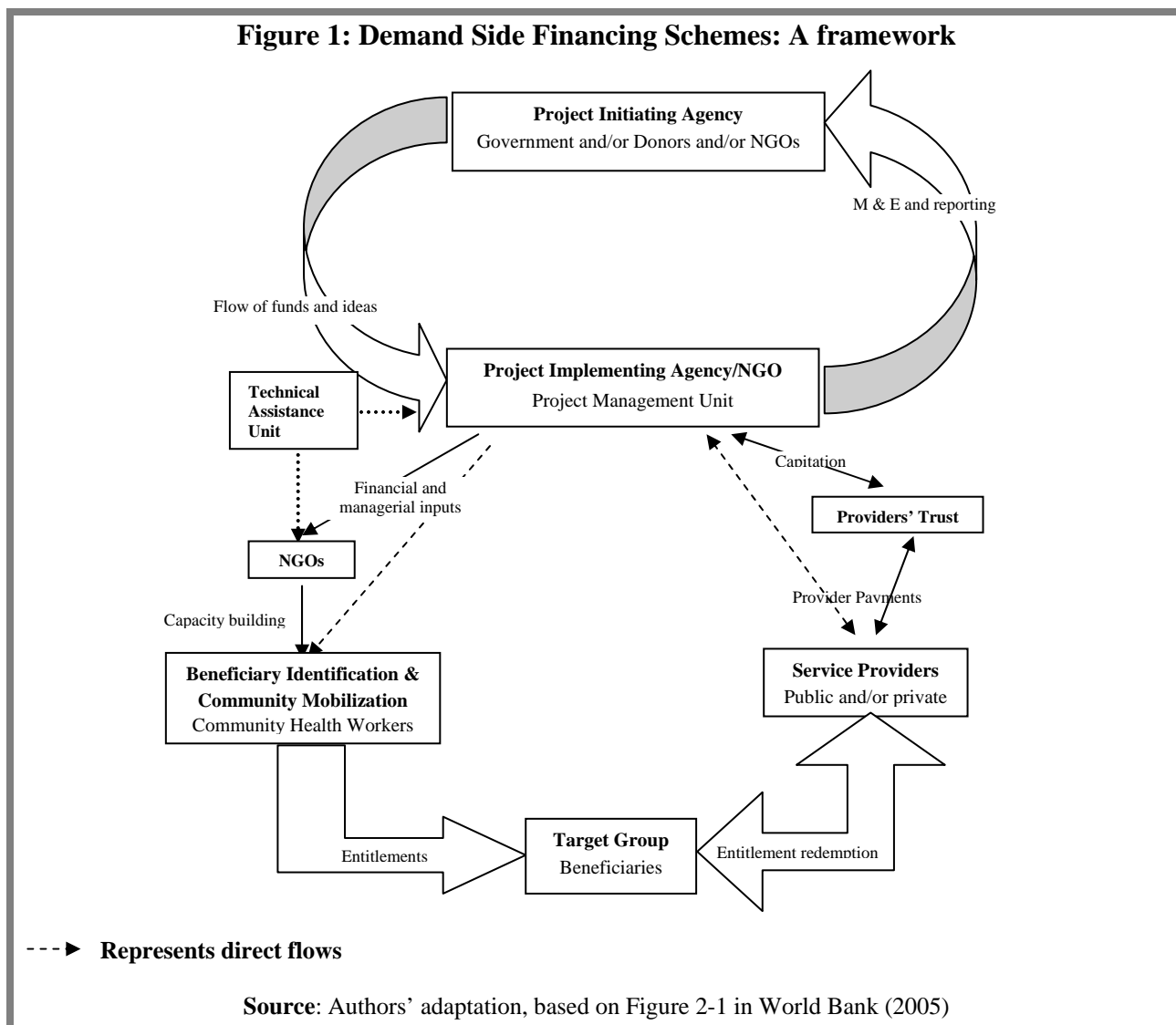
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<sup>4</sup> [www.icas.net/.../Voucher%20schemes%203%20case%20studies%20WB%20KfW.doc](http://www.icas.net/.../Voucher%20schemes%203%20case%20studies%20WB%20KfW.doc)

and present a schematic to enable an operationally easier way of classifying various health financing schemes.

### 3. Demand-side Financing: A Template

Before presenting the schematic or template of DSF parameters, a review of the broad financial and administrative circuit of such financing schemes is discussed briefly below.



In general, DSF schemes have a structure similar to the one presented in Figure 1. There are, however, differences across schemes and some of the links may not always be applicable. For instance, while almost all such schemes have the government or a donor agency as the initiator with funds, there may or may not be a separate implementation agency. There are instances in India (for example CINI-ASHA)



where the voucher paperwork is handled by the NGO identified as an intermediary between the donor and the beneficiaries. In most cases, using civil society organizations to implement such schemes is seen to be the best approach, since these organizations have local knowledge about the community. The implementation agency can make significant contributions in technical assistance during the designing, planning and operation of the scheme. The funds are then transferred to the agency which manages the distribution of entitlements such as cards/vouchers/coupons to the target population directly or through third-party organizations such as hospital trusts or community health workers, which in turn distribute them to sections of the target population with which they have close links. The recipients take these cards/vouchers/coupons to a health service provider (of their choice if applicable) and redeem them for goods or services (or use them in partial payment). The service providers (private/public) then submit these cards/vouchers/coupons or other entitlement evidence to the agency, along with the reported utilization. The mode of provider payment used is generally capitation.

A positive attribute of voucher schemes is that they enable regular monitoring of uptake of goods and services, and give fairly accurate data on program outputs and outcomes, which can then be used by the government and/or the donor to evaluate their schemes. In the absence of monitoring and evaluation departments within the project/scheme management unit, evaluation is sometimes outsourced to other agencies such as research organizations.

While the foregoing discussion is broadly indicative of the way in which DSF schemes work, it still does not enable easy classification of the various schemes based on clearly defined parameters. We now present a possible template based on our review of the DSF literature as well as other similar mechanisms in order to establish a clear taxonomic basis and to facilitate better understanding of the various schemes that can be included under the DSF umbrella.

Close scrutiny of the definitions, interpretations and examples of health financing schemes indicate that there are three core features of a DSF scheme. These are:

*1. Pre-specified target group:* For example pregnant women belonging to families below poverty line, or members of poor households with a particular disease, or those who require to be screened for the presence of a particular disease etc.

*2. Financial transfers to the beneficiaries:* these transfers can be from a variety of organisations (government, private, NGO) and in a variety of ways (vouchers, conditional cash transfers).

3. *Rationale for choice of services covered:* services covered under DSF schemes have the character of merit goods, those with large positive externalities, or preventive services that are either not provided in adequate amounts or not demanded in optimal quantities because of market failure: ex. immunization, reproductive health, preventive care like cancer screening

The remaining characteristics may differ from scheme to scheme, depending on the initiating agency and the rationale for starting the scheme in the first place.

4. *Choice of providers:* tying the services to more than one provider

5. *Public-private mix of providers:* involvement of private sector in addition to government providers

6. *Provider incentive:* incentives for service delivery. For example pay-for-performance to health workers for community mobilization

7. *Third party involvement:* involvement of insurance agency, NGOs etc.

8. *Stand-alone or integrated:* The DSF scheme may run on its own or it may be a part of a bigger scheme under CHI or other health schemes.

As already stated, the first three features constitute the core of DSF and the remaining characteristics may be considered optional. By the same token, there are other modes of health financing that may share some of the characteristics of DSF, but which are disqualified because they do not incorporate the core features. For example, Social Health Insurance (SHI) provides health insurance through targeting and by proportional contributions, but SHIs or other social transfers schemes in health do not focus on particular under-used or essential services and, therefore, do not fulfil criterion 3 as defined above.

There are a number of examples of CHI schemes that have been put in place mainly to make services available and accessible to the most vulnerable members of the population, and to reduce the burden of health costs on households (for example, the CHIs schemes of Grameen bank in Bangladesh or SEWA in India). It is entirely possible for such initiatives to design DSF schemes as a subgroup within the overall services these programmes provide. As will be seen in the next section, the distinctions between DSF schemes and other health insurance schemes in such instances can sometimes be ambiguous.

As for provider choice, competition and incentives, some schemes make the receipt of incentives conditional upon generation of certain outputs and therefore serve to raise productivity. Provider competition is at the core of productivity-based remuneration as well as evidence-based practice, both tied to improved performance from the supply side (Sandiford et al. 2003, Luft 1984)

While such competition is certainly a desirable feature of any health system from an equity and efficiency point of view, it is not essential for a successful DSF initiative. If the main aim is to improve uptake of a particular service, the presence of adequate quantity and quality of just a few or even one provider would still achieve that objective. Similarly, whether the providers belong to the public or private sector has little bearing on the accomplishment of the objective of increased service utilisation.

Most examples of DSF schemes involve more than one organisation; often the national government is involved together with a donor and a local community-based organisation like Self Help Groups or NGOs. The involvement of the government is certainly desirable, from the point of view of replicability and scalability. The involvement of donors is often essential, given the costs of launching a DSF scheme. Finally, since local organisations are the most familiar with the relevant issues and beneficiaries, there are good reasons to involve them in the operationalizing of the scheme. Certain DSF initiatives emphasise the importance of training, building human capital from among the community to increase ‘ownership’ of the scheme and to develop local capacity. Additionally, there may be cases where reinsurance plays a part and an insurance company is able to finance all or part of the costs of coverage. However, this is neither necessary nor always desirable for a DSF scheme to be successful.

In the next section, we use the template described above, and apply it to the Indian context.

#### **4. DSF in India: An analysis of selected cases**

In India, schemes usually termed “DSF schemes” and seen as innovative financing mechanisms, are generally aimed at improving maternal and child health. However, our template allows us to include other schemes operating in the health sector under the DSF category as well - schemes that have not hitherto been included in discussions of DSF in India (see Bhatia et al. 2006).

**Table 1: Demand side financing schemes in India**

Schemes	Specific Target	Financial transfers	Merit good	Choice of providers	Public private mix	Provider incentives	Intermediaries	Integrated
Agra voucher	✓	✓	✓	✓	✓	✓	✓	
Arogya Raksha	✓	✓	✓	✓	✓	✓	✓	
Chiranjeevi Yojana	✓	✓	✓	✓	✓	✓	✓	
CINI-ASHA	✓	✓	✓	✓	✓	✓	✓	
Dr. Muthulakshmi Reddy memorial scheme	✓	✓	✓					
Janani Suraksha Yojana	✓	✓	✓	✓	✓	✓		✓
Janani Suvidha Yojana	✓	✓	✓	✓	✓	✓	✓	
Mamta	✓	✓	✓	✓	✓	✓	✓	✓
Rashtriya Swasthya Bima Yojana	✓	✓	✓	✓	✓		✓	
Sambhav voucher scheme	✓	✓	✓	✓	✓	✓	✓	
Sarva Swasthya Mission (Maternity Vouchers)	✓	✓	✓	✓	✓	✓	✓	✓
SEVA Mandir voucher scheme	✓	✓	✓	✓		✓		
Yashashvini health insurance	✓	✓	✓	✓	✓		✓	

Note: Specific target - ✓ if the scheme is limited to certain well defined population subgroup. Financial transfers - ✓ if beneficiary receive subsidy in cash or through vouchers. Significant externalities – ✓ if the services targeted through the scheme can generate significant externalities.... Choice of providers: ✓ if yes. Public private mix - ✓ if yes. Provider incentives: ✓ if yes. Involvement of intermediaries: ✓ if yes; integrated with other schemes ✓ if yes.

Table 1 lists some selected DSF schemes operating in India and indicates their salient characteristics, arranged according to relevance in defining DSF. The symbol “✓” in a cell indicates the presence of the respective characteristic. Additional details regarding these characteristics are provided in Annex 1. It must be stated here that there may be many more health financing initiatives and schemes that should have been included in this table. However, it was neither feasible nor possible to collect information on all such schemes from the various states. Thus, while 12 listed cases might comprise only a small sample of the DSF schemes in India, these are sufficient to test the use of the template and enable a broader understanding of the application of DSF.

All the cases in Table 1 meet the first three criteria and therefore qualify as DSF. They all use pre-specified target groups, involve financial transfers, and focus on maternal and child health that can be easily classified as merit goods or goods with significant positive externalities. The combination of targeting and earmarking grants (in the form of voucher or health card or membership roll number) is the core of DSF in India. These schemes (*Janani Suraksha Yojana*, *Seva Mandir* voucher scheme), connect the beneficiaries (mainly women in reproductive ages and newborns) with the health system through beneficiary vouchers or any other token (*CINI-ASHA*, *Chiranjeevi Yojana*) which is accepted by a panel of providers (including private providers) and are reimbursed by the project management. For example, the *Seva Mandir* voucher scheme - an NGO led initiative - works in distant villages around the Gujarat-Rajasthan border region (the Tribal Belt). Some schemes (for example *Janani Suvidha Yojana*, *Agra Voucher Scheme*) – which are mainly state-led initiatives – offer cash benefits for the utilisation of key services as prescribed in the programme strategy. The programme design of major state-led initiatives (such as *Janani Suraksha Yojana* (JSY) under the umbrella of the National Rural Health Mission) suggests that financial incentives are key to improved reproductive and child health outcomes. One recent example of provider-led DSF is the Mamta scheme launched by the Delhi government (Government of Delhi 2008), which includes significant financial incentives for providers to register and follow up cases for institutional delivery. While most of the schemes listed here have many of the additional features of DSF, they differ across the characteristics of providers: choice of providers, public-private mix, involvement of intermediaries and the extent of integration with other schemes or services.

There is a good mix of public and non-state led initiatives that are implemented through village level health workers including ASHAs (Accredited Social Health Activist<sup>5</sup>). In fact most of the state-led initiatives visualise an active role for NGOs and private providers in the operation of the schemes.

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<sup>5</sup> ASHAs has a key role in National Rural Health Mission of India. As a village level health worker ASHAs are expected to provide preventive and promotive health-care services.

Among the selected schemes, the Agra voucher scheme, CINI-ASHA, SEVA *Mandir* and *Sambhav* voucher schemes are stand-alone schemes and are non-state led initiatives. Non-state led schemes often have differently defined target groups, though these too focus on reproductive and child health. Agra and *Sambhav* voucher schemes are designed for women of reproductive age living below the poverty line. However, CINI-ASHA includes women of reproductive age and adolescents residing in slum areas in its target group, whereas *Seva Mandir* focuses primarily on women residing in the areas of the scheme's operation.

Most of the state led initiatives have matching (means testing) criteria to define the target group (for example, women of reproductive age living below the poverty line). While the BPL definition is itself problematic, for operational purposes most of the Indian schemes have simplified the identification procedure and have relied upon local authorities to identify the poverty status of households. For example, Dr. *Muthulakshmi Reddy* memorial maternity assistance scheme adopts a procedure that relies on village level health workers or authorities to devise the criteria to identify the poverty status of women before enrolling them as beneficiaries.

A major state-led initiative is the *Janani Suraksha Yojana* (JSY), which offers cash incentives to the beneficiaries for utilising the specified reproductive and child health-care services. Cash assistance under the scheme is integrated with antenatal care during the pregnancy, institutional care during delivery and the immediate post-partum period in a health centre by establishing a system of coordinated care through field level health workers. The *Chiranjeevi Yojana* scheme operating in Gujarat provides transport assistance and compensation to the village level health worker if she stays with the pregnant women in the health centre for delivery. After the delivery, the woman is encouraged (through cash benefits in JSY) to visit the health facility or *Anganwadi* centres<sup>6</sup> for the immunization of the newborn. Under most of the schemes monetary benefits are also provided to the village level health workers after the process is completed.

There are many operational differences in the schemes as they tend to vary with regard to the number of ante-natal care (ANC) visits, the basic ANC services and medication, institutional delivery care, whether or not they include services of immunization and the type of provider incentives. Since the lack of adequate human resources is an important bottleneck in the Indian health system, all the selected state-led

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<sup>6</sup> *Anganwadi* centre is a government sponsored child-care and mother-care center in India. It caters to children in the 0-6 age group. Started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition, *Anganwadi* centre is mainly managed by the *Anganwadi* worker. She is a health worker chosen from the community and given 4 months training in health, nutrition and child-care.

initiatives have partnered with the private health provider sector. Bhat and colleagues (2007) found that private providers are attracted to voucher schemes because the voucher clients increase their patient volumes and hence revenue. Studies also reveal the fact that the absence of protocols can lead to over-prescription of drugs, and abuse of the subsidies given to the providers. The component of quality control is critical in the resource poor settings before implementing DSF schemes (LaGuarde 2007, Bhat et al 2007)

The multiplicity of schemes operating in a certain target region can also affect the performance of the schemes. For instance, an evaluation study of the Agra voucher scheme notes that many of the women who accessed the ANC services either did not use or have not yet used the voucher delivery benefit (Donaldson et al 2008). The report argues that payment incentives under JSY are a major factor in drawing Agra voucher scheme beneficiaries into utilizing the JSY scheme for institutional delivery. Clearly, mechanisms to check the duplication of schemes in target areas are critical in the cost-effective functioning of any one scheme. Consistent with allocative as well as technical efficiency, there is a need to think of integration and sharing of responsibilities rather than duplicating efforts and undermining schemes' effectiveness. The Agra voucher evaluation also notes that the expected output levels for provision of FP services (i.e., IUCD insertion or sterilization) were based on existing norms; however, performance against these output indicators has also been very low. The report cites the influence of non-monetary factors on rural women's use of voucher benefits. These factors include more traditional beliefs and practices, illiteracy or low levels of literacy, limited awareness of the value and availability of services, and limited access to transportation and/or long travel distances.

There are a few schemes in India where an identification (*viz* BPL card), health card or a membership roll number entitles a household or an individual to utilise an earmarked amount of services, but the schemes do not qualify as DSF mainly because they fail to meet criterion 3. Schemes that are devised to give health cover or encourage use of general health services cannot be considered as DSF and on that count two important schemes in India, the *Rashtriya Swasthya Bima Yojana* (RSBY) and the Employee State Insurance Scheme (ESIS) can be safely excluded from this discussion. The latter is a typical SHI and the former is an effort by the government to extend health insurance to cover hospitalization for BPL populations.

Evaluations of DSF schemes in India are limited. Among these schemes *Chiranjeevi Yojana* has received considerable research attention in comparison to other schemes. Its assessment finds that the scheme is well-targeted and considerably reduces out-of-pocket expenditures related to institutional delivery. It is

entirely free of charge for BPL families for medicines and transportation (Bhat et al 2009). The study suggests that the scheme needs to be strengthened by including more funds for medicines, transportation, etc. and offering at least two antenatal and two postnatal visits. It also recommends that there is a need to take into account the considerable variations among the health facilities in terms of the range, quality, and cost of services. However, a proper evaluation of the scheme could have answered the counterfactual: what would have been the trends in the indicators for institutional deliveries in the absence of the scheme? Gujarat - being an economically progressive state - would probably have seen the utilization of services improve consistently over time, even without such schemes. Thus, the incremental effectiveness of the scheme might be lower than would appear from mere process data.

Evaluation of schemes and the study of the underlying determinants of particular schemes' performance are essential to understand whether schemes performing well in their small respective areas will sustain their momentum if scaled-up or replicated elsewhere. If DSF schemes are used to change the behavior of the beneficiary then evaluation also has to take into consideration the cultural and behavioural settings in the country before replication. Clearly, varying socio-cultural factors and traditional outlook determine the extent to which a particular scheme will be effective. Basically, the more such schemes attempt to change behavior, the more these will have to be context specific.

As will be argued below, the rationale for providing financial incentives for better uptake of services remains somewhat unclear, especially for maternal services and other services, the demand for which need not always have a one-to-one relationship with economic status. The choice of tool for the financial transfer - for example vouchers versus cash transfers - would also depend on the underlying assumptions. If it is assumed that monetary constraints prevent mothers from taking care of basic nutritional and other pregnancy related expenses then it makes sense to encourage disbursement of cash benefits. If it is assumed that institutional visits and deliveries would improve if made offered free of charge, then specific vouchers would be the better option. Evidence from India (NFHS-3) indicates that institutional deliveries are not always a function of economic status; many non-BPL households choose to have their deliveries at home as well. In such cases, the rationale of DSF itself needs to be re-examined. The use of financial incentives including cash transfers needs to be handled sensitively, especially because it can become political in nature and used as a populist measure without sufficient research into the factors that inhibit demand.



## 5. DSF: A Critical Appraisal

There have been few very comprehensive reviews of the global literature on DSF schemes and their evaluation (Ensor 2004a, 2004b LaGuarde 2007). The literature on consumer-led vouchers (see Table 1 Ensor 2003, Glassman et al. 2009) including competitive vouchers and OBA seems to suggest that the effectiveness of means-testing as a targeting strategy depends upon implementation capacity and works best when used for predictable services for identifiable groups. It therefore is most successful when used in conjunction with services for pregnant women, newborns, sufferers from chronic priority diseases and disability. Such schemes seem to offer the most benefit in increasing access for marginalized/poor population groups, as experience in Latin America indicates<sup>7</sup>. It also works for groups that are discriminated against or whose activities are considered illegal, such as Injecting Drug Users or Commercial Sex Workers (Prata et al 2009, Ensor 2004a, 2004b Gorter and McKay 2007).

In Bangladesh, the voucher scheme is documented as having improved institutional deliveries and reproductive health in the areas these have been launched (Schmidt et al 2010). The schemes surveyed in India also have been largely successful in improving maternal health in the target populations (Bhat et al 2009 and Donaldson et al 2008).

Both in India and in other parts of the developing world, DSF is seen as a way to improve the uptake of services by the most deprived sections of the population, who may otherwise be constrained by the lack of financial wherewithal. However, before endorsing such claims it is essential to obtain evidence that DSF has increased the utilization of services or uptake of health interventions in areas where such schemes have been launched. A comprehensive evaluation would require a technical outcome evaluation study with well designed controls to understand the benefits of DSF relative to situations where there is no DSF. From the point of view of scalability or donor interest, a cost-effectiveness study is desirable as well.

The World Bank in its handbook *Guide to Competitive Vouchers in Health* (World Bank 2005) sets out several different layers for Monitoring and Evaluation (M&E). These are:

- Monitoring costs
- Monitoring service quality
- Monitoring competition between providers
- Monitoring to detect abuse of the voucher scheme
- Monitoring the characteristics of voucher recipients and redeemers

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<sup>7</sup> [www.icas.net/new.../Background%20Paper%20Competitive%20vouchers.doc](http://www.icas.net/new.../Background%20Paper%20Competitive%20vouchers.doc)

- Monitoring and evaluating health outcomes
- Monitoring and evaluating impact on equity and poverty reduction
- Monitoring and evaluating cost effectiveness

While the first few bullets are often studied, there is scant literature on the last three indicators, especially from South and South-East Asia. Thus, while there is abundant literature and studies on the usefulness of vouchers, there are only a handful of technically sound evaluations done on DSF. Generally, there are very few impact evaluation studies of development initiatives in key sectors in the developing world (Evaluation Gap Working Group 2006), and this holds true especially for some regions like South and South East Asia. Interestingly, there have been a number of studies evaluating conditional cash transfers (CCT) in middle income countries in Latin America. A review of selected studies (Rawlings 2005) that have used experimental or quasi-experimental methods for evaluation indicates that programmes launched in Colombia, Honduras, Mexico, Nicaragua and Turkey have been successful in addressing some of the drawbacks of standard social assistance programmes, though there are many concerns regarding the replicability and scalability of such programmes. For example, a study on the cost-effectiveness of competitive vouchers in Nicaragua to treat Sexually Transmitted Diseases (STI) indicated that vouchers were highly cost-effective (Borghi et al 2005).

The lack of evaluation data on health interventions has prompted some to devise innovative M&E schemes, as in the case of the United Republic of Tanzania national voucher scheme for distributing insecticide-treated nets (Hanson et al 2008). One study finds that the Tanzanian national voucher scheme is a cost-effective way of delivering subsidized insecticide-treated nets to vulnerable groups (Jo-Ann Mulligan 2008). In Uganda, there has been some interest in evaluating output-based aid projects, and systems have been put in place for rigorous evaluation. In this regard it is worth noting that the Population Council has launched an important initiative that evaluates reproductive health voucher programmes and has created a Reproductive Health Voucher Resource Centre (see <http://www.rhvouchers.org/>), which will be a key resource for policymakers, donors and programme managers seeking to learn from the experiences of other countries in order to decide what might work for them. The primary objectives are: a) to evaluate the impact of voucher and accreditation programmes for reproductive health status and b) assess the effect of such programmes on access to, quality of, and to reduce inequities in the use of selected reproductive health services at facilities.

The most recent evaluation from South Asia comes from Bangladesh, where a team has recently completed a detailed evaluation study on the voucher scheme for maternal health. The evaluation compares DSF program intervention *upazilas* to matched control *upazilas*, in order to evaluate the

demand-side and supply-side impacts of the program, and also conducts a focused assessment of program operations in DSF *upazilas* (Hatt et al 2010).

Nevertheless, based on international experience as well as Indian case studies (including Bhat et al 2009, Donaldson 2008,), the following positive effects of DSF can be safely mentioned:

- Significant improvements in utilization of the targeted service by the target population
- Reduction in out-of-pocket expense and opportunity costs associated with health seeking

Some key concerns remain, however; these are:

**Inadequate supply and poor quality:** Inadequate numbers of trained physicians and health workers remain key bottlenecks in many areas, and cannot be addressed by DSF schemes. This constraint has been mentioned especially in the context of OB-GYN health personnel in India (Acharya and McNamee, 2009 ILO, 2006). Moreover, the quality of care remains a concern both at public and private health facilities, as has been mentioned in numerous instances in policy documents (Government of India 2006).

If there are a handful of providers with inadequate skills and training (Singh et al, 2007), which is often the case in rural and remote areas, even a competitive voucher scheme may not ensure quality services. The quality of health care in cities is not satisfactory either. A report of the Comptroller and Auditor General of India for Delhi for the year ending March 2009 has pointed out that 68% of deliveries in the city took place in homes or in private dispensaries with inadequate infrastructure about which the health department had no information (see Ghosh A, Times of India 14 April 2009). In addition to such issues, frequent turnover of government personnel responsible for ensuring the smooth functioning of such schemes is also a supply side constraint to the extent that it can hold up key supply and infrastructural inputs (Donaldson et al 2008).

**Narrowly focused DSF:** Demand Side Financing schemes with a narrow focus may have limited impact on final goals; for example, if the aim is to reduce maternal mortality and neo-natal mortality, it may be critical to include a range of services like ANC and PNC care for mothers including nutrition which is a critical component in this context (Bhat et al 2009).

**Adverse incentives:** The DSF schemes may have adverse incentives in terms of provider-based remuneration/pay-for-performance: for example, the possibility of over-prescribing a services (like C-section) has been frequently mentioned as a drawback (Acharya and McNamee, 2009). In fact, the widely implemented JSY scheme also has an additional (monetary) provision to cover C-Section

deliveries. Evidence of higher prescription of C-Sections can be observed from the early evaluation of Agra voucher scheme ( Donaldson et al 2008); however, the results from the Chiranjeevi yojana does not lend support to this hypothesis (see Bhat et al 2009). There have been questions raised about, for example, the effectiveness of unconditional cash transfers which can generate wrong kind of incentives. There are also concerns that provider-led schemes that are not well-designed may provide perverse incentives to providers resulting in mere registration of patients without follow-up (, Ghosh 2010) leading to high drop out rates.

**Low uptake of services:** Other non-financial barriers like socio-cultural norms, attitudes and practices can limit the uptake of certain services (see the following discussion based on NFHS data). For areas where these factors are significant, DSF on its own may not achieve the desired goals: for example, specific cultural norms like delivery in the mother's home may act as a constraint in follow-up visits. A recent report on Delhi government's Mamta scheme to promote institutional deliveries indicates that there is massive drop-out from the scheme after the registration. While the reasons could be faulty design of the DSF scheme with adverse incentives for providers to merely register and not follow up on patients, it could also be due to sociocultural factors that result in low uptake of services subsequently (Ghosh A, Times of India 14 April 2009). There is also a need to increase awareness among the health workers and volunteers so that demand generation can be a continuous process.

**Targeting:** Targeting is an issue in large populations with no easy identification system in place. The scope for mismanagement and corruption are also present. In the absence of strict vigilance it provides reasonable scope for mistargeting of beneficiaries or of malpractices in the delivery of benefits ( Hatt et al 2010, Powell-Jackson et al 2009).

**Capacity and professional management of schemes:** If such schemes have to be scaled up, there is a need to go beyond NGO-managed initiatives and create professional capacity and infrastructure that can handle large financial and administrative through-put, especially in the relatively disadvantaged (in terms of manpower) rural areas. This issue has been mentioned in many contexts of NGO-run schemes, and comes out clearly for DSF schemes in Madhya Pradesh and Gujarat (Government of India 2007).

**High costs & sustainable donor funding:** DSF schemes require sound planning, administrative and management structure and skills, with continuous monitoring and evaluation. This indicates that significant financial and non-financial resources need to be committed on a continuous basis. Clearly, the source and continuity of funding is important in this regard, and schemes will fare differently on the cost criterion. For example, Gujarat's Chiranjeevi yojana appears to have faced fewer constraints than emerges from an early review of the pilot of the Agra voucher scheme (Bhat et al 2009, Donaldson et al

2008). Countries need to plan carefully and in advance for sustainable financing to ensure that effective programmes are not brought to an abrupt halt.

A key question that needs to be posed in planning to implement a DSF scheme concerns the other non-financial barriers to uptake of services mentioned above. In this regard some preliminary evidence is presented from India's National Family Health Survey (NFHS) to highlight the role of such barriers. Table 2a and 2b indicate the percentage of women who had a live birth without any ANC visit and the percentage reporting 'home' as the place of delivery over the last two rounds of the NFHS conducted during 1998-99 and 2005-06. It is immediately clear from the table that, at the all-India level, the percentage of women<sup>8</sup> having a live birth without an ANC visit has gone down between the two periods, and is quite low at around 23%. However, it is of concern to note that around 61% of women<sup>9</sup> still report 'home' as the place of delivery, clearly indicating that ANC visits probably do not always prompt institutional deliveries. Although there is a negligible decline in non-institutional deliveries in both rural and urban areas, it is disconcerting to observe the high (above 70%) levels of non-institutional deliveries in rural areas.

**Table 2a: Percent women (who had live birth) without ANC visit**

	<i>Urban</i>	<i>Rural</i>	<i>Total</i>
<b>NFHS 2 (1998-99)</b>	13.6	39.8	34.0
<b>NFHS 3 (2005-06)</b>	9.3	27.7	22.8

**Table 2b: Percentage reporting 'home' as place of delivery**

	<i>Urban</i>	<i>Rural</i>	<i>Total</i>
<b>NFHS 2 (1998-99)</b>	33.9	74.3	65.4
<b>NFHS 3 (2005-06)</b>	32.3	70.9	61.0

*Source: IIPS and ORC Macro 2000, NFHS 2 1998-99 India & IIPS and Macro International 2007, NFHS 3 2005-06 India: Volume I*  
**Note:** The reference period for NFHS 2 is three years preceding the survey. The same for NFHS 3 is five years.

<sup>8</sup> Percentage of women who had a live birth in the five years preceding the survey by antenatal care (ANC) provided during pregnancy for the most recent live birth, India, NFHS 2005-06 (IIPS and Macro International 2007)

<sup>9</sup> Percentage of women who had live births in the five years preceding the survey and reported home as the place of delivery, India, NFHS 2005-06 (IIPS and Macro International 2007)

The NFHS 2005-06 also obtains information from both men and women<sup>10</sup> on the reasons for not delivering in a health facility; these responses are reported in table 3 below. As can be seen, the major reasons for opting for non-institutional deliveries are non-financial in nature. This raises serious concerns about the quality of information, education and communication of public health messages; around 40% of men and 70% of women do not think it is necessary to deliver in a health facility. In fact, an additional 15% of the men report that the family did not think it was necessary for (or did not allow) the mother to undergo institutional delivery. This is discouraging evidence from both supply and demand side, and for the health system in general. The table does indicate significant presence of financial constraints, however; almost one-fourth of the concerned respondents cite direct financial reasons for not delivering in a health facility. Around 10 percent of women have cited transportation barriers and availability issues as major hurdles in accessing health facility for delivery. It is also interesting to note that a higher percentage of men have cited transportation problem as a major barrier, which in turn is higher in rural compared to urban areas. From the perspective of DSF schemes working in remote areas, this is useful information that can be folded into existing or new schemes.

**Table 3: Reasons for not delivering in health facility, NFHS 3 2005-06**

<b>Men</b>	<b>Reasons</b>	<b>Urban</b>	<b>Rural</b>	<b>Total</b>
	Man did not think it was necessary/did not allow	38.8	40.7	40.4
	Family did not think it was necessary/did not allow	20.3	14	15
	Child's mother did not want check-up	10.4	9.1	9.3
	Has had children before	1.5	1.6	1.6
	Costs too much	14	20.7	19.6
	Too far/No transportation	1.2	3.9	3.4
	No female health worker available	0.9	1.4	1.3
	Other	3	2	2.2
	Don't know/Missing	9.8	6.5	7
	Total	100	100	100
<b>Women</b>	<b>Reasons</b>	<b>Urban</b>	<b>Rural</b>	<b>Total</b>
	Costs too much	21.5	26.9	26.2
	Facility not open	2.3	3.6	3.4
	Too far/No transport	5.3	11.8	11
	Don't trust facility/Poor quality service	4	2.4	2.6
	No female provider at facility	1.3	1.1	1.1
	Husband/Family did not allow	6	5.9	5.9
	Not necessary	69.6	72.1	71.8
	Not customary	5.5	6.5	6.3
	Other	5	2.7	3

**Source: IIPS and Macro International 2007, NFHS 3 2005-06 All India Report**

**Note: The reference period for NFHS 3 is five years.**

<sup>10</sup> Percentage of women who had a live birth in the five years preceding the survey by reasons for not delivering the most recent live birth in a health facility, India, NFHS 2005-06 (IIPS and Macro International 2007). Percent of men age 15-49 whose youngest living child age 0-35 months was not delivered in a health facility by the main reasons for not delivering in a health facility, India, NFHS 2005-06 (IIPS and Macro International 2007).

As further evidence of the role of non-financial barriers we also report the reasons for no ANC visits for both men and women from NFHS 3 in Table 4. About 65% of the men and 70% of the women stated non-financial issues pertaining to customs and awareness. Fifteen to 20% of the reasons had to do with costs.

**Table 4: Reasons for No ANC Visit (NFHS 3 - Men & NFHS 2 - Women)**

<b>NFHS-3 (2005-06) MEN</b>			
<b>Reasons</b>	<b>Urban</b>	<b>Rura</b>	<b>Total</b>
<b>Man did not think it was necessary/did not allow</b>	38.8	40.7	40.4
<b>Family did not think it was necessary/did not allow</b>	20.3	14	15
<b>Child's mother did not want check-up</b>	10.4	9.1	9.3
<b>Has had children before</b>	1.5	1.6	1.6
<b>Costs too much</b>	14	20.7	19.6
<b>Too far/No transportation</b>	1.2	3.9	3.4
<b>no female health worker available</b>	0.9	1.4	1.3
<b>Other</b>	3	2	2.2
<b>Don't know/Missing</b>	9.8	6.5	7
<b>Total</b>	100	100	100
<b>NFHS-2 (1998-99) WOMEN</b>			
<b>Reasons</b>	<b>Urban</b>	<b>Rural</b>	<b>Total</b>
<b>Not necessary</b>	63.4	59.1	59.5
<b>Not customary</b>	3.8	4.3	4.3
<b>Costs too much</b>	11.3	15	14.7
<b>Too far/No transport]</b>	0.9	3.9	3.7
<b>Poor quality service</b>	1.6	0.8	0.8
<b>No time to go</b>	2.6	1.7	1.8
<b>Family did not allow</b>	11.3	8.2	8.5
<b>Lack of knowledge</b>	3.2	4.2	4.1
<b>No health worker visited</b>	0.2	1.6	1.5
<b>Other</b>	1.7	1.1	1.2
<b>Total</b>	100	100	100

*Source: IIPS and ORC Macro 2000, NFHS 2 1998-99 India & IIPS and Macro International 2007, NFHS 3 2005-06 India: Volume I*

**Note: The reference period for NFHS 2 is three years preceding the survey. The same for NFHS 3 is five years.**

These statistics are extremely important as far as DSF is concerned and can have significant implications for the performance and effectiveness of the schemes. If the DSF is being designed to overcome barriers

of costs and transport, then clearly it would only address part of the problem. There would remain a large percentage of women who would not be able to use the vouchers, for example, since she would either not be motivated, interested or allowed to. If non-financial barriers are a major reason for low utilization, DSF is not the best solution, unless accompanied by interventions to improve information and awareness (Eichler et al 2009). However, such an approach would be more costly and the cost-effectiveness of such integrated interventions would need to be carefully evaluated before launching.

While there is awareness regarding barriers like lack of education about when to seek care, lack of information about what care is available, and intra-household and gender preferences (Ensor, 2004a), it is not always clear that these barriers can be effectively overcome by DSF schemes. While narrowly focused interventions using DSF may work well in improving the utilization of services such as screening for breast cancer, it is not clear that this is the best approach for primary health care services targeted at the poor. This is also relevant for services with large externalities, which go beyond merely the poor and need a different approach. It is important to ask the question whether a piece-by-piece approach is the best way to improve utilization in the long run, especially for services like maternal care. Integration with other services is ultimately the most cost-effective way of improving outcomes from the perspective of the government. The context is important: when bed nets are essential to prevent malaria, giving vouchers makes sense, because it is a tool that is simple to understand and implement; but for services like reproductive health, where many other social, cultural, and geographical parameters become important, a more integrated approach might be called for.

Clearly, the elaborate investment in public health systems in countries such as India was precisely aimed at providing subsidized care for the poor and the vulnerable. The improper functioning of the health systems cannot be taken as given and additional systems cannot be put in place to fill the gaps. This approach may be counterproductive and allow further deterioration of the government systems. If health systems strengthening (HSS) is seen as an important objective of donor funding – as it is for the Global Fund for example - then it is important to combine both supply and demand side solutions to (a) improve quality of health systems and (b) encourage utilization of services by the most needy.

DSF is a good concept and has worked well in different circumstances, but the main concerns have been around sustainability. Most of the studies reviewed raise the question of the long term sustainability of the DSF programmes, which really is relevant in this context. Developing countries cannot and should not have to depend on the continuous supply of donor funds to implement costly DSF programmes to improve utilization of primary health care services, especially if the context is more complex than a mere financial barrier to uptake.



## **6. Conclusion**

Ultimately, countries have to understand what the critical barriers are to utilization to devise effective solutions. In a way, each of the case studies reviewed have implicit in them a set of assumptions about the determinants of service utilization (Glassman et al 2009). If DSF is the choice of financing, the assumption is that financial constraints are key to lower utilization. Where provider incentives are put in, the assumption is that there is reasonable assurance about quality. If consumers are left to choose from a set of providers, it is implicitly assumed that such a set already exists with reasonable quality assurance. The template presented in this paper allows one to test each of those assumptions while formulating as well as evaluating demand side financing schemes.

The fact is that very seldom are the assumptions mentioned, discussed or questioned explicitly, especially before launching a scheme. The aim of this paper is to enable anyone intending to use DSF to use the template as a potential planning device. It can also enable evaluation of the schemes by examining each of the underlying assumptions that go with the 8 characteristics mentioned above.

Finally, a sound, well-functioning public health care system with a well-regulated private health care system is the goal in countries like India. This, combined with a sound health coverage system and accompanied by improvements in socioeconomic parameters including education, is probably going to remain the most cost-effective solution to low utilization of key services for the poor in the long run.

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## Annex 1

<b>Agra Voucher Scheme</b>	
<b>Specific target group:</b> Yes, individuals in reproductive ages belonging to below poverty line households (in Agra, Kanpur (all slum dwellers), Haridwar, Gumla and Dhanbad).	
<b>Financial transfers :</b> Yes, through vouchers for family planning and reproductive health services and immunization	
<b>Key service covered :</b> Reproductive and child health	
<b>Choice of Providers :</b> Yes	
<b>Public private mix :</b> Yes	
<b>Supply side incentives:</b> Performance based reimbursement to ASHAs for institutional deliveries with all the components of ANC, PNC and immunization under the Voucher Scheme	
<b>Involvement of intermediaries:</b> Yes, NGOs and health volunteers are involved in mobilizing beneficiaries, management and disbursement of vouchers (along with the Nursing homes, block development officer and voucher management units.	
<b>Stand alone:</b> Yes	
<b>Provider or consumer led:</b> Provider led	
<b>Currently functional:</b> Yes	
<b>Arogya Raksha</b>	
<b>Specific target group:</b> Beneficiaries are restricted to only those below poverty line with only one or two children	
<b>Financial transfers:</b> Yes, through Arogya Raksha certificates issued by medical officer the person and two of her/his children below the age of five years are covered under the hospitalization benefit and personal accident benefit schemes. The person and/or her/his children could get in-patient treatment in the hospital upto a maximum of Rs. 2000 per hospitalization, and subject to a limit of Rs. 4000 for all treatments taken under one Arogya Raksha Certificate in any one year. She/he gets free treatment from the hospital, which in turn claims the charges from the New India Insurance Company. In case of death due to any accident, the maximum benefit payable under one certificate is Rs. 10,000.	
<b>Positive externalities :</b> Yes, positive externalities attached to health in general and limited family size specifically.	
<b>Choice of Providers :</b> Yes	
<b>Public private mix :</b> Yes	
<b>Supply side incentives:</b> Performance based reimbursement to ASHAs for institutional deliveries with all the components of ANC, PNC and immunization under the Voucher Scheme	
<b>Involvement of intermediaries:</b> Yes, SHGs and ICDS workers to mobilize people to adopt terminal family planning methods after completion of family	
<b>Stand alone:</b> eligible for free hospital treatment only if sterilisation had been carried out in a government hospital.	
<b>Provider or consumer led:</b> Provider led	
<b>Currently functional:</b> Yes	
<b>Chiranjeevi Yojana</b>	
<b>Specific target group:</b> Pregnant women from poor families living Below Poverty Line (BPL)	
<b>Financial transfers:</b> Private providers deliver “cash less” maternity services to BPL families with reimbursement for the local travel expenses (ambulance) on the basis of a <i>Chiranjeevi Yojana</i> (CY) card issued by AWW, FHW or ANM.	
<b>Positive externalities:</b> Yes, under this scheme the FHW, AWW or ANM follows expectant mother	

	from the beginning till post-delivery. The CY cards are issued in third trimester to the expectant mother. The scheme provides not only post-partum care but also initiates child immunization services
	<b>Choice of Providers :</b> Yes, the beneficiaries can choose from among the nearest empanelled private providers
	<b>Public private mix :</b> Yes, the private providers have been listed and signatory to MoU with the government
	<b>Supply side incentives:</b> No specific incentives are given, apart from decided capitation rate per delivery.
	<b>Involvement of intermediaries:</b> No intermediaries (NGOs are present in the places where Panchyati Raj Institutes (PRIs) are not present.
	<b>Stand alone:</b> Yes
	<b>Provider or consumer led:</b> Provider led
	<b>Currently functional:</b> Yes in all the districts of Gujarat
<b>CINI-ASHA West Bengal</b>	
	<b>Specific target group:</b> Pregnant women, children under two years and adolescents
	<b>Financial transfers :</b> on the payments of user fees (INR 5) per visit, client gets a consultation voucher, on the payment of user fees (INR 10) as user fees, client gets a voucher for subsidized diagnostic services
	<b>Positive externalities : externalities associated with mother and child care,</b> CA's engagement with children on street and young people required that the program focus include adolescent health care, RTI/STI and HIV/AIDS
	<b>Choice of Providers :</b> yes, there is an option private medical practitioners from among a network
	<b>Public private mix :</b> Yes, women are registered for ANC and postnatal checkups in government health posts. Private medical practitioners also refer complicated cases to third level government hospitals.
	<b>Supply side incentives :</b> honorarium is offered to community health volunteers to motivate the target group
	<b>Involvement of intermediaries :</b> yes, community health volunteers
	<b>Stand alone:</b> no
	<b>Provider or consumer led:</b> Provider led (referral vouchers)
	<b>Currently functional:</b> -- NA--
<b>Mamta, Delhi</b>	
	<b>Specific target group:</b> Pregnant women from BPL SC/ST households, aged 19 years and above
	<b>Financial transfers :</b> Rs. 4000 to the providers and Rs. 600 to the beneficiary (under JSY)
	<b>Positive externalities :</b> Externalities associated with mother and child care
	<b>Choice of Providers :</b> Empanelled providers
	<b>Public private mix :</b> Women are registered for ANC and postnatal checkups in government health posts. Private medical practitioners also refer complicated cases to third level government hospitals.
	<b>Supply side incentives :</b> honorarium is offered to community health volunteers to motivate the target group
	<b>Involvement of intermediaries :</b> yes, community health volunteers
	<b>Stand alone:</b> yes
	<b>Provider or consumer led:</b> Provider led
	<b>Currently functional:</b> Yes
<b>Dr. Muthulakshmi Reddy Maternity Assistance Scheme</b>	
	<b>Specific target group:</b> Maternity assistance to the poor women
	<b>Financial transfers:</b> A sum of INR 6000 is given to the expectant mother based on the recommendations of the village health nurse even without their income certificate.
	<b>Positive externalities:</b> The externalities associate in enabling pregnant women to have adequate nutrition.

	<b>Choice of Providers :</b> Not applicable
	<b>Public private mix :</b> Not applicable
	<b>Supply side incentives :</b> Not applicable
	<b>Involvement of intermediaries :</b> Not applicable
	<b>Stand alone:</b> Yes
	<b>Provider or consumer led:</b> Consumer led
	<b>Currently functional:</b> Yes, started in 2009-2010
<b>Janani Suraksha Yojana:</b>	
	<b>Specific target group:</b> BPL pregnant women with a focus on low-performing states namely 8 EAG states and Assam and J&K and the remaining NE States
	<b>Financial transfers :</b> A <b>voucher</b> is given along with admission slip for delivery, amounting to mother's package plus the transport assistance money is given to the expectant mother and that she should be able to cash the same at the Hospital's cash counter, at the time of discharge.
	<b>Positive externalities :</b> The scheme helps avoid complications during delivery thus preventing maternal mortality
	<b>Choice of Providers :</b> Yes, the beneficiaries can choose between accredited private providers (norm being at least two per block on the basis of criterion/protocol of accreditation by block development officer)
	<b>Public private mix :</b> Yes, empanelled doctors or private hospitals wherever government institutions are not available
	<b>Supply side incentives:</b> cash incentives to accredited social health activists (ASHA) to encourage institutional deliveries. There has been a proposal to introduce incentives for private providers.
	<b>Involvement of intermediaries :</b> The ASHA has been the main intermediary
	<b>Stand alone:</b> Yes
	<b>Provider or consumer led:</b> Consumer led
	<b>Currently functional:</b> Yes in all Low Performing States which including 8 EAG states and Assam and J&K and the remaining NE States
<b>Sambhav voucher scheme</b>	
	<b>Specific target group:</b> Yes, individuals in reproductive ages belonging to below poverty line households (in Agra, Kanpur (all slum dwellers), Haridwar, Gumla and Dhanbad). The scheme is running as pilot in Jharkhand for family planning services only
	<b>Financial transfers :</b> yes, through vouchers for family planning and reproductive health services and immunization
	<b>Positive externalities :</b> yes, positive externalities attached to family planning and reproductive and child health
	<b>Choice of Providers :</b> yes
	<b>Public private mix :</b> yes
	<b>Supply side incentives:</b> Performance based reimbursement to ASHAs for IUDs inserted under the Voucher Scheme in Uttarakhand USAID initiative
	<b>Involvement of intermediaries :</b> yes, NGOs and health volunteers are involved in mobilizing beneficiaries, management and disbursement of vouchers
	<b>Stand alone:</b> yes
	<b>Provider or consumer led:</b> provider led
	<b>Currently functional:</b> yes
<b>Sarv Swasthya Mission (maternity vouchers)</b>	
	<b>Specific target group:</b> All BPL families
	<b>Financial transfers :</b> Vouchers are given to the expectant mother for ANC, institutional delivery and for post natal care including immunization
	<b>Positive externalities :</b> associated with the institutional delivery and post natal care with immunization



	<b>Choice of Providers :</b> Yes
	<b>Public private mix :</b> Yes, existence of PPP
	<b>Supply side incentives :</b> Yes, the AWWs and ANMs get performance based incentives
	<b>Involvement of intermediaries :</b> Yes, various stakeholders operating at the community level
	<b>Stand alone:</b> Operating within a social health protection program by Jharkhand govt. + ILO
	<b>Provider or consumer led:</b> Provider led
	<b>Currently functional:</b> Yes
<b>Seva Mandir voucher scheme</b>	
	<b>Specific target group:</b> Pregnant women residing in remote villages on the Gujarat–Rajasthan border (Seva Mandir’s catchment area)
	<b>Financial transfers:</b> There are no financial transfers to the beneficiaries
	<b>Positive externalities:</b> Yes, because they involve antenatal checkups postnatal checkups deliveries, handling complications in time and immunization. The Dai receives financial incentive and becomes more acceptable among families.
	<b>Choice of Providers :</b> It is at the discretion of beneficiary and Dai to choose among providers (public or private)
	<b>Public private mix:</b> It is Seva Mandir’s individual initiative.
	<b>Supply side incentives:</b> Dais have a coupon booklet which is given to expectant mother for maternity care and immunization. On each visit these coupons are collected by Dais and can be monetized by presented it to Seva Mandir through village committees
	<b>Involvement of intermediaries :</b> No
	<b>Stand alone:</b> Yes (Seva Mandir is also running a different insurance based programme on a pilot basis)
	<b>Provider or consumer led:</b> Provider led
	<b>Currently functional:</b> Yes
<b>Yashashvini Health Insurance</b>	
The state government, for its part, has made its infrastructure of post offices available to collect the 5 INR premium, and issue a “Yashaswini member card.	
	<b>Specific target group:</b> Members of farmers cooperative and their dependents under the aegis of the Karnataka State Co-operative Department. It is voluntary for cooperatives to participate.
	<b>Financial transfers:</b> This is a contributory scheme wherein the beneficiaries (through cooperatives) contribute a small amount of money every year to avail cashless treatment during the period.
	<b>Positive externalities:</b> The programme covers most of all health treatments. Therefore, presence of externality - the characteristic feature of DSF - in the nature of services covered cannot be extended to this scheme.
	<b>Choice of Providers :</b> The beneficiaries are offered cashless treatment at the Network of Hospitals spread across the state of Karnataka.
	<b>Public private mix :</b> Yes, this is a primarily a private initiative with the support of private providers and with limited financial contribution by the government
	<b>Supply side incentives :</b> Apart from the capitation fee per consultations/surgeries no specific supply side incentives offered under the scheme
	<b>Involvement of intermediaries :</b> Yes, Family Health Plan Limited has been appointed by Yashashvini trust as implementing agency for implementation of the scheme
	<b>Stand alone:</b> Yes
	<b>Provider or consumer led:</b> Consumer led
	<b>Currently functional:</b> Yes
<b>Janani Suvidha Yojana</b>	
	<b>Specific target group:</b> Expected mother in the urban slums in Haryana irrespective of age and/or parity will be eligible for the voucher scheme. There are certain benefits to high risk complicated pregnancies on the basis of referral vouchers

	<b>Financial transfers:</b> In terms of Vouchers for antenatal checkups, delivery, postnatal check-up, various referral cards
	<b>Positive externalities:</b> Associated with the maternal and child care together with family planning services provided post child birth.
	<b>Choice of Providers :</b> Empanelled private providers on the basis of certain selection criterion
	<b>Public private mix :</b> The providers are private along with the civil surgeon as a referral
	<b>Supply side incentives :</b> Sakhi will give undertaking to District NGO and will get performance based honorarium after completion of a set of activities.
	<b>Involvement of intermediaries :</b> NGOs are selected at the district levels
	<b>Stand alone:</b> Yes
	<b>Provider or consumer led:</b> Referral vouchers makes it provider led but otherwise the scheme is consumer led
	<b>Currently functional:</b> Yes