





## 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.

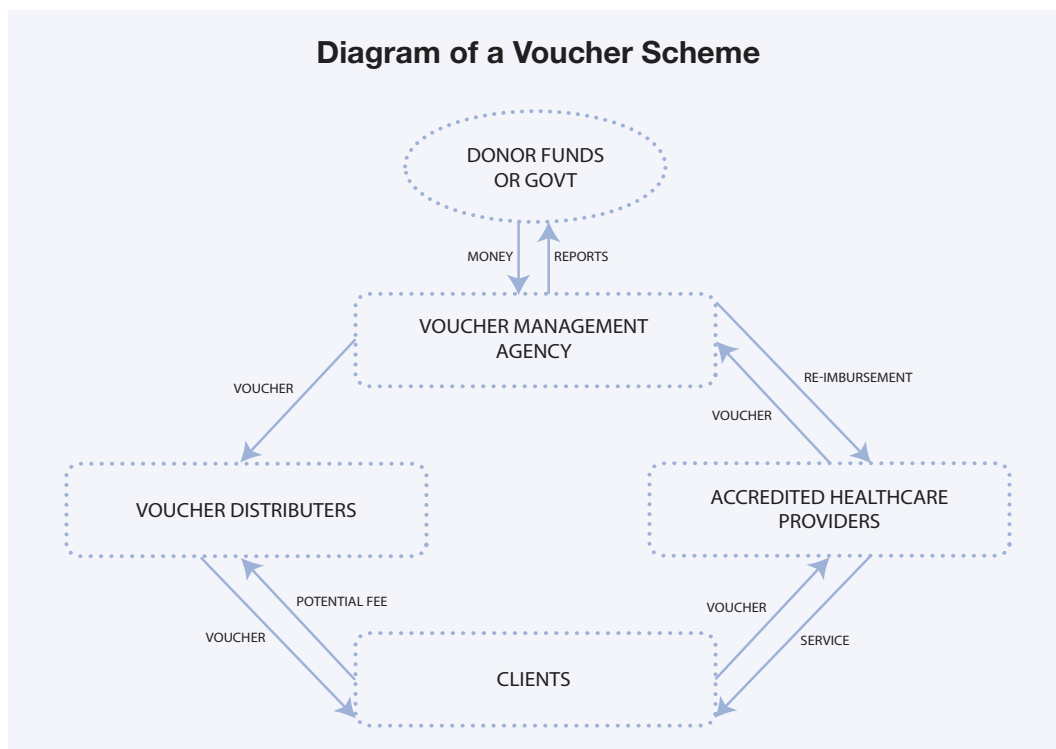
Uganda (awaiting full impact assessment in 2010):

- 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”

### Diagram of a Voucher Scheme



“Voucher schemes can play an important role in Health System Strengthening”



### 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.

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