

USING DEMAND-SIDE FINANCING IN REPRODUCTIVE HEALTH

Background

More than one-third of Pakistanis live below the poverty line. Since 62% of the health expenditure is out-of-pocket, this poverty directly limits access to healthcare and diminishes health outcomes. As a consequence Pakistan has one of the highest Maternal Mortality (276 per 100,000 births¹), Infant Mortality (41 per 1000 births) and Fertility rates (3.4 children per woman) in the world. Health constitutes less than 1% of the total GDP of Pakistan and over 80% of health expenditure is spent on curative services. In part this reflects a lack of demand for life saving reproductive health services and in other part it reflects the lack of the public sector to provide health services to the poor. Additionally, limited health funding is further aggravated by inefficient health systems that mean that the same service costs much more in the public than in the private sector.

This brief discusses the role and challenges of Social safety nets (SSN) and Demand Side Financing (DSF) to help marginalized households and promote positive reproductive health (RH) behaviors in them. International evidence suggests a substantial role of SSN and particularly DSF to help alleviate poverty² and facilitate development³.

The Gap

Under spending on part of the government means most health expenses are out of pocket. This burden is highest for the poorest and limits their access and uptake of health services. Reproductive health services which relate to women are particularly underutilized in the face of poverty, lower priority for women in the society, and lack of recognition of benefits of such services. These have led to low rates of contraception use and skilled birth attendance – services that save women's lives.

Demand Side Financing

Social safety nets and demand side financing can subsidize the high costs and facilitate uptake of family planning and reproductive health services for the marginalized, allowing the government (or other funders) to help overcome both demand side (lack of recognition of the value of services) and supply side (lack of availability or access to services) to providing women with reproductive health services.

DSF helps induce healthy behaviors among communities by creating incentives to using to avail certain services. It places the power to seek and avail the services in the hands of consumers, thus empowering them as "paying customers". It also creates incentives for providers of services – especially for profit providers - to make these services available by creating a market for these services. DSF can be used in health to:

¹ Pakistan Demographic and Health Survey 2006-7.

² Devereux S. Can social safety nets reduce chronic poverty? *Development Policy Review* 2002;20:657-675

³ Grosh ME, Del Ninno C, Tesliuc E, uerghi A. For Protection and Promotion: The design and implementation of effective safety nets. 2008. Washington, D.C., The World Bank

SALIENT POINTS AND RECOMMENDATIONS

- DSF schemes can effectively improve uptake of FP and RH services
- Facility births in remote rural locations would be ideally suited for a DSC scheme
- Partner with private health providers in rural/remote areas to provide FP and RH services through DSF schemes
- Once DSF schemes are used to source out FP/RH services, the current management and personnel should be right sized to reduce costs
- Supplement DSF and SSN schemes with socio-economic development

- 1) Promote equitable distribution of health services
- 2) Increase utilization of existing health systems
- 3) Create a need for preventive services
- 4) Create demand for services and stimulate supply

Experiences from Pakistan

DSF and incentive schemes are not new to Pakistan. Several schemes have been initiated in selected areas of Pakistan; yet their footprint remains small. There is however, sufficient local experience now to allow scale up of DSF by government and international donors. Some of this experience is described below.

In the public sector the Benazir Income Support Program (BISP) provides health vouchers for health costs up to Rs. 25,000 per family; and the Punjab Health Sector Reform Program (PHSRP) subsidizes reproductive healthcare through distribution of health cards in three districts of Pakistan⁴.

Some private sector initiatives implemented by international and national organizations include:

- Marie Stopes Society (MSS) – a subsidiary of Marie Stopes International (MSI) identified marginalized women in remote/rural areas and provided vouchers for IUCD insertions, follow-ups and removal. These vouchers were distributed within the catchment area of their Suraj providers. In a span of six months (January to June 2010), MSS redeemed 8,642 IUCD vouchers⁵.

⁴ Health department. Punjab Health Sector Reform Programme. 2012. Government of Punjab, Pakistan. Dec-12-2012.

⁵ Boler T and Harris, L. Reproductive Health Vouchers: from Promise to Practice. London: Marie Stopes International, 2010. Available at:

- Contech International and the Zahanat Foundation provided Sehat Sahulat Cards in Kasur and Rawalpindi to increase the accessibility of quality maternal, newborn and child health (MNCH) care.
- In a 12 month intervention, Greenstar Social Marketing distributed vouchers for maternal health and institutional delivery in Dera Ghazi Khan. The schemes resulted in a 22% increase in antenatal care visits, 22% increase in institutional delivery and a 35% increase in postnatal care visits.⁶
- Greenstar has also successfully used conditional cash transfers (CCT) in Jhang to help overcome financial barriers to institutional delivery⁷.

Lessons Learnt

Globally, DSF interventions have induced positive health behaviors by exposing selected marginalized to reproductive health seeking behaviors. These schemes have also resulted in positive indirect changes or “externalities” within the communities such increased availability and lower cost of services from private providers. Evidence from Bangladesh suggests DSF scheme influenced even non-intervention households to avail health services⁸. Following lessons will be key to future successful DSF interventions:

- DSF works where supply systems are already in place. The effectiveness of DSF schemes also depends on distance to health facility, and transport costs. When designing DSF schemes, such indirect expenses for the users must be built into the model.
- Until now most DSF schemes are project based with limited sustainability. Since behavioral change requires time, DSF schemes for short durations do not guarantee high impact. Thus, long term sustainability needs to be built into programs.
- Sustainable behavior change also requires parallel economic and social developments⁹. Ensuring access to food, water & sanitation, education, employment and providing support through infrastructure development and security are essential to ensure that the induced health behaviors are sustained.

Recommendations

Pakistan has some of the worst health indicators in the world; a high population growth rate; and more than one third living below the poverty line. After grinding progress (0.5% annual increase) in the past 5 decades, the contraceptive prevalence rate declined by 3% in 2011-12¹⁰. Despite the rhetoric the overall public sector contribution to health has remained under 1% for decades under civilian and non-civilian governments and it is highly unlikely this will change dramatically. Under the circumstances, the public sector can use DSF schemes to provide some necessary health services to

the poorest, while reducing the costs of services. In order to do so it must:

- Consider large scale up of FP and RH services using a DSF model. NGOs already operate in many locations to provide services. The government can fund these services directly AND withdraw its own employees from those locations. Here the lessons must be learnt from the case of the People’s Primary Care Health Initiative (PPHI), where the government outsourced health facility management to an NGO and also kept all of its health management personnel in place – leading duplication of costs and operational “turf” battles.
- Facility births in rural locations are ideally suited to a DSF scheme. In this case the government would develop vouchers that can be redeemed by private providers. This would work around the need for the public sector seeking – with little success – to place doctors in remote rural locations.
- The resources the government saves by these schemes must be invested in developing the social value within communities such as improving road and communication infrastructure which ultimately improve the living conditions and therefore the health of communities.

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<http://www.mariestopes.org/sites/default/files/vouchers-from-promise-to-practice.pdf>

⁶ Agha S. Impact of a maternal health voucher scheme on institutional delivery among low income women in Pakistan. *Reproductive Health*. 2011 May 3; 8:10.

⁷ Agha S, Carton TW, Thomas W. Determinants of institutional delivery in rural Jhang, Pakistan. *International Journal for Equity in Health* 2011;10:31.

⁸ Schmidt JO, Ensor T, Hossain A, Khan S. Vouchers as DSF Instruments for Healthcare: A Review of the Bangladesh Maternal Voucher Scheme. *Health Policy* 2010;96:98-107.

⁹ McKeown T. *The role of medicine: dream, mirage or nemesis?* 1976. London, Nuffield Provincial Hospitals Trust.

¹⁰ Highlights of the Pakistan Economic Survey 2011-12. Available At: http://www.finance.gov.pk/survey/chapter_12/highlights.pdf