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PRIMER FOR POLICYMAKERS

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Vouchers for Health: A Focus on Reproductive Health and Family Planning Services

Health care policies in developing countries have traditionally focused on public financing and provision. The provision of health care in the public sector is largely financed through supply-side subsidies. Low-priced or officially free public health care was intended to ensure the entire population's access to care. However, there now is evidence that in many developing countries, people, including many poor, seek better-quality health care in the private sector and pay out of pocket. The extra financial burden this imposes on the poor results in unequal access to care and low utilization of needed services and products, such as reproductive health/family planning (RH/FP) services and products.

In response, policymakers are trying various demand-side approaches to financing health care, that is, subsidizing the consumer of health care directly. One approach is the use of vouchers. Vouchers are targeted at identified underserved groups (such as the poor), for specific services (such as RH/FP), and usually are for use in the private sector, as public care is supposed to be free or low cost.[1]

While some countries have run voucher programs for education or for food supplementation for the poor for many years – the U.S. Food Stamp Program is one example – significant developing country interest in vouchers for health services is more recent, with programs taking place over the past decade or less. Many of these programs have been related to RH/FP services, such as provision of antenatal care, hospital delivery, family planning counseling and products.

This primer, intended for policymakers, donors, health care practitioners, and others involved in health care policy making and planning, draws on several overview papers on vouchers programs

Vouchers for subsidizing health care

Vouchers for health are a financing mechanism for subsidizing the price of health services and products to target population groups, with the goal of improving access to and utilization of those services and products.

Voucher programs for health services and products

Developing countries have only recently experimented with voucher programs for RH/FP and other health services and products:

- *RH/FP including maternal health:* Bangladesh, China, Kenya, Nicaragua, Uganda
- *Child health:* China
- *Malaria (insecticide-treated bednets for pregnant women and children):* Tanzania

[1] Vouchers can be used for public care to waive user fees. This primer discusses vouchers for private sector care.

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and demand-side subsidies (see Bibliography). It discusses key aspects of voucher programs, elements for assessing the feasibility of a prospective program, and steps for designing and implementing a program where feasible. It identifies lessons learned from earlier voucher programs for health, despite the fact that the number of programs and literature about them are limited, highlighting how vouchers have been used to increase utilization of and access to RH/FP services and products.

1. WHAT IS A VOUCHER?

Vouchers for health subsidize the price of health services and products, such as delivery assisted by skilled personnel or family planning counseling, to underserved population groups, such as the poor and/or otherwise disadvantaged. Subsidies go directly to the health care consumer (patient) in the form of a voucher – a certificate or other token – that the consumer redeems when seeking care, usually from a private sector provider. Depending on the level of the subsidy associated

Demand-side vs. supply-side financing of health care

Demand-side financing: In this type of financing, government or donor money goes directly to consumers in the form of a subsidy; consumers use this subsidy to buy services and products. The policy goal is to increase access to and utilization of the identified service or product by a targeted group, usually the poor or otherwise underserved. Demand-side financing may be in the form of cash transfers or conditional cash transfers, where provision of cash hinges on the beneficiary using a specified service. Another form of demand-side financing is vouchers, in which the consumer gets a certificate or other token that covers all or part of the price of the service or product (or package of benefits). The consumer typically has choice in deciding where to purchase the good or service, usually in the private sector from among program-approved suppliers. An example of a conditional cash transfer program for health care is the Oportunidades Human Development Program in Mexico (previously called PROGRESA; see Gertler, 2000 and program website, http://www.oportunidades.gob.mx/). Examples of voucher programs are mentioned throughout this primer.

Supply-side financing: In this type of financing, a government or donor subsidy goes to the provision or supply of services and products, traditionally in the public sector. For health care, subsidies cover costs of health service inputs such as public hospital and other facility infrastructure, staff, and equipment, as well as health care products such as drugs and contraceptives. Consumers may receive the services and products free of charge, or they may have to pay part of the price.

By providing inexpensive or free medical care, countries hoped that all citizens – including the poor and vulnerable – would have sufficient access to health services and products. However, due to difficulty in reaching certain population groups, the low quality of some public health care, informal payments, and other reasons, supply-side interventions often underserve the poor. Evidence now shows that in many developing countries, even where public care is officially available free of charge, the poor seek better quality health care in the private sector and pay out of pocket. Unexpected medical needs, such as treatment for delivery complications, can be financially catastrophic. Alternatively, the poor go without care.

Due to a realization that supply-side interventions alone have not succeeded in meeting policy goals such as equal access to care for all citizens, utilization of specific services, and maintaining a certain level of quality of care, demand-side health financing mechanisms, including vouchers, are growing in popularity. These mechanisms are attractive because they remove financial barriers to access to health care. They allow target populations (such as the poor) to buy specified services and products, that is, they create a direct link between the subsidy and output; indeed, they are an incentive to increase use of that output. Thus, they are becoming popular with donors as a form of output-based aid. When combined with other interventions such as behavior change communication and information, education and communication campaigns, they can be a powerful tool to increase access to specific health services and products by the poor and underserved.

For further discussion of demand-side subsidies and comparison to supply-side subsidies see Ensor (2004) and World Bank (2005).

with the voucher, services and products may be provided free of charge or at reduced price from providers participating in the voucher program.

Voucher programs, if well designed and well administered, can help achieve a broad range of common RH/FP policy goals: improving equity, efficiency, quality, access, and choice in RH/FP services.

- **Access and equity**. By reducing financial barriers, vouchers can increase utilization of quality health services by the poor and other underserved groups, as vouchers can be targeted directly at those groups. Vouchers also can help to bypass bureaucratic channels susceptible to corruption – making the voucher redeemable only by the designated individual or group increases the likelihood that the covered health service is indeed provided to the targeted persons.
- **Choice**. Competitive voucher programs allow consumers to choose from a pool of preapproved private sector providers.
- **Efficiency and quality**. In addition to voucher program participation requiring a minimal level of quality in services and products, competition among private sector providers to obtain the business of voucher holders can further improve quality and lower prices.

Voucher programs can be non-competitive or competitive. Non-competitive programs assign a voucher recipient to a health care provider. Competitive programs allow recipients to choose from a pool of providers who are preapproved to participate in the program (preapproval seeks to ensure a minimal level of quality of care and efficient program management). This choice creates competition among participating providers and is an incentive for providers to improve service quality – if they do not, voucher holders may seek care elsewhere.

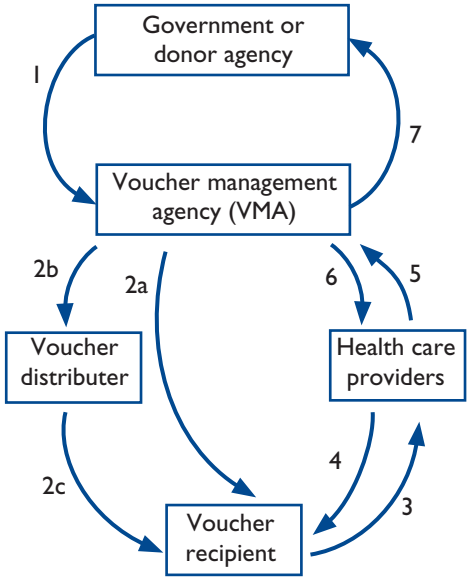
This primer discusses competitive private sector programs – the literature has focused on these, as have the country programs discussed here.

2. HOW DOES A VOUCHER PROGRAM WORK?

Later sections will provide details about the feasibility, design, and implementation of a voucher program. Here, the basic steps of a functioning voucher program are described. Figure 1 illustrates these steps, with the numbered arrows corresponding to the steps enumerated in the side text boxes.

Figure 1: Steps in a typical voucher program

1. Government or donor agency establishes a voucher management agency (VMA) and transfers funds to the VMA
2. VMA produces vouchers and distributes them to the target population, either:
   - 2a: directly by itself, or
   - 2b: through a third-party voucher distributer, who
   - 2c: offers them to the target clients



3. Voucher recipient selects a provider and takes the voucher to the provider of choice (and redeems the voucher for a pre-specified service or product)
4. Provider accepts voucher and delivers service or product
5. Provider returns vouchers received to VMA (with any necessary documentation)
6. VMA pays the service provider a contracted amount for each returned voucher
7. VMA monitors program and reports outcomes to the funding agency

Source: Adapted from World Bank, 2005.

While individual vouchers flow in the step sequence, all the steps are occurring simultaneously once the voucher program is operating.

The government or donor that funds the voucher program transfers funds to a neutral voucher management agency (VMA) to implement the program (step 1); the VMA administers the rest of the process. The VMA produces the vouchers and distributes them directly to recipients (2a), or gives them to a third-party distributor (2b) that then distributes them (2c). The voucher recipient selects a participating private sector health care provider and redeems the voucher by giving it to the provider, in exchange for receiving the service or product covered by the voucher (3); simultaneously, the provider accepts the voucher and delivers the covered service or product (4). The provider then submits redeemed vouchers to the VMA for reimbursement, along with other documentation of services rendered as stipulated in the provider's contract (5). The VMA reimburses the provider the contracted amount for each returned voucher (6). The VMA does monitoring and evaluation (M&E) of the program and reports outcomes to the funding agency (7). The VMA may contract out this M&E aspect to a third party but will generally have to work closely with them throughout the life of the program.

3. WHAT ARE LESSONS LEARNED FROM VOUCHER PROGRAMS?

While there have been only a small number of voucher programs in health to date, they provide useful lessons for designing voucher programs for RH/FP services and engaging the private sector. These lessons are presented below with corresponding examples from different country programs.

Target vouchers to population groups that are identifiable and reachable. To ensure that the target population will increase its use of the desired health service and to reduce misuse, the criteria and process for identifying voucher recipients should be clear. It is best to target groups that share a characteristic or have an identifiable illness, for example:

- Pregnant women
- Infants and young children (below a specified age)
- High-risk groups (such as sex workers) for sexually transmitted infections (STIs)
- Priority diseases that take time to treat such as malaria and tuberculosis

Define benefits packages that are easily identifiable. Vouchers programs yield best results when they clearly define the standardized package of care that they will cover. This makes it easier to explain and market the program to the target population and reduces costs for providers and for the VMA, by clarifying which services and products are covered and therefore are reimbursable. Examples include the following:

- Specified antenatal care such as four antenatal visits and two doses of tetanus toxoid immunization
- Delivery assisted by a skilled health personnel
- STI diagnosis and treatment
- Malaria treatment for pregnant women, with specified course of drugs and insecticide-treated bednets (ITNs)

Targeting identifiable groups with defined benefits packages

Nicaragua: Adolescents age 12-20 were the target population for vouchers for free access to RH care in public and private health clinics.

Tanzania: Pregnant women and children under 5 were the target groups for vouchers for insecticide-treated bednets at subsidized prices.

United States: Low-income pregnant women and children under 5 at nutrition risk are the target groups for vouchers for nutritional supplements in the Women, Infants, and Children (WIC) program, in effect since 1974.

Importance of pricing vouchers to ensure use

Tanzania: Cost of an ITN to the poorest voucher recipients was too high, even after the voucher subsidy, deterring use in this group.

China: Vouchers for hospital delivery did not provide sufficient subsidy for the poorest women to afford this service, even with the voucher.

Price the voucher in line with target population's ability and willingness to pay. One reason for low use of vouchers in some programs has been the inability of the target population to pay for the unsubsidized portion of the price of the product or service. If the voucher is not a full subsidy, i.e., the user must make a copayment, then it is important to understand the users' ability to pay. A willingness-to-pay study may have to be conducted; this can be costly and time-consuming but the information garnered is critical in determining the appropriate subsidy – and ensuring uptake of the voucher program by the target population. Otherwise, the whole purpose of a voucher program may be defeated.

Raise community awareness about the voucher program. Low use of vouchers in some programs was attributed to the targeted population's lack of knowledge and understanding of the program. Substantial time and effort may have to be expended to make the target population aware of the specifics of the program through formal information, education, communication (IEC) campaigns. This may take months and use multiple communication channels.

Raising awareness and communicating benefits to recipients and providers

Tanzania: Evaluation of the ITN voucher program found low awareness of the program (only 43 percent of the target groups) after two years and only 12 percent of women used a voucher to purchase an ITN.

Nicaragua: The adolescent RH voucher program had a specific component of training for providers to improve quality of service. Doctors and staff at participating clinics received training about the program as well as about adolescent RH care. This communication contributed to users with vouchers being slightly more satisfied with quality than were users without vouchers.

Communicate benefits of the voucher program both to recipients and service providers. Along with awareness about the existence of the program, the benefits of the subsidized products or services need to be explained to the target population. This often requires a significant behavior change communication (BCC) program. For example, for a voucher program on safe motherhood to succeed, the benefits of deliveries assisted by skilled health personnel must be communicated to and understood thoroughly by the target population, especially when tradition dictates home deliveries. Program benefits and procedures also should be communicated to participating providers, so that they know how to work with voucher holders.

Monitor program. Any voucher program should be monitored from the start in order to understand how the target population perceives the program; the extent to which, and why, they are using the program; how providers perceive the program; the overall impact of the program; and what adjustments are needed. Monitoring is also needed to detect fraud or abuse of the voucher program, such as recipients misrepresenting themselves or providers misrepresenting services provided for higher reimbursements. Monitoring will help to improve the program and to determine sustainability and scale-up. It will also help generate lessons learned for other voucher programs.

4. WHEN SHOULD VOUCHERS BE USED? JUDGING THE FEASIBILITY OF A VOUCHER PROGRAM

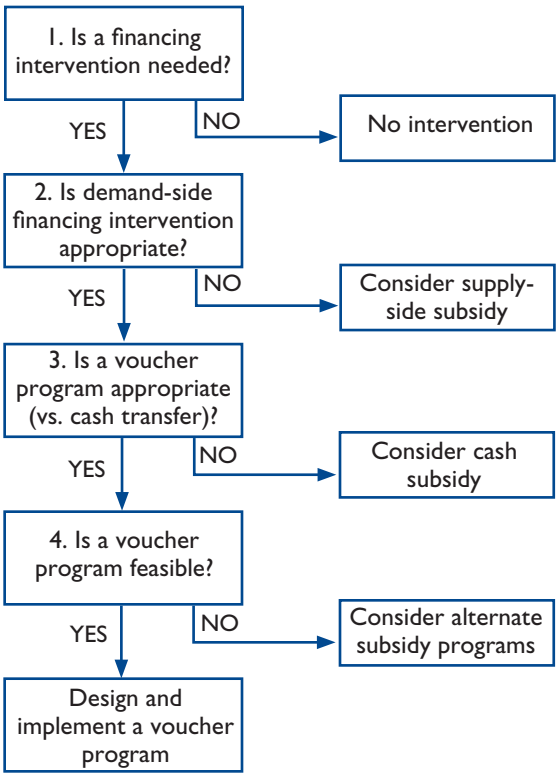
Despite their potential contributions to achieving the policy goals discussed in Section 1, voucher programs (and other demand-side subsidies) are successful only if they can implement certain strategies:

- **Target a defined population in need of an available service.** Voucher programs are most appropriate where a population that is easily defined – by income level, gender, etc. – is in need of a service or product that is available from a number of providers, but lacks the financial means to access the service or product.
- **Change consumer behavior and increase demand.** Removing the financial barrier to accessing services and products that are associated with health benefits, such as deliveries assisted by skilled health personnel or family planning counseling, may not by itself boost utilization. To stimulate demand, vouchers may need to be combined with BCC and IEC campaigns to explain health benefits and the voucher program itself.
- **Promote competition.** As noted above, vouchers can be used to increase consumer choice and improve the performance and accountability of a particular sector of providers. The best-known example of this is in the education sector, where publicly funded vouchers enable children to attend presumably better private schools, and simultaneously encourage public schools to improve in order to retain students.

Figure 2 illustrates steps by which a feasibility study can determine if a voucher intervention is appropriate in a given country context (Ensor 2003, Ensor 2004, and World Bank 2005 explain this process in more detail). The first two steps involve determining whether a financing intervention is indeed needed in the first place, and if yes, if a demand-side financing mechanism, such as a voucher is the appropriate approach.

Step 1: Determine whether a financing intervention is needed. The decision will depend on the existence of a financial barrier to access the health services and products being considered for a voucher program. Data from household surveys, such as the Demographic and Health Survey, may provide evidence on the health care needs and financial constraints of

Figure 2: Determining the need for and feasibility of a voucher intervention



Source: Adapted from Ensor (2004).

the target population. If secondary data do not exist, primary data will need to be collected to determine the existence of a financial barrier to access. The decision on whether a financing intervention is appropriate will also depend partly on issues of social justice, equity, and efficiency as perceived by policymakers; therefore, discussions with stakeholders should be held to understand the importance of these issues in the country context. Proceed to step 2 only if there is a clear need for a financing intervention.

Step 2: Determine whether demand-side financing is appropriate. Understand the local context and discuss with stakeholders to decide if policy goals suggest that a demand-side (rather than supply-side) financing intervention is appropriate. There are two main issues to consider in making this decision: (1) Can effective targeting of low-income and vulnerable groups be done through a demand-side program or do obstacles like corruption or lack of community programs (through which to market and administer the voucher program)

impede reaching target populations? Traditional supply-side mechanisms generally have not been good at targeting poor and vulnerable groups. However, if the target population is localized, supply-side interventions (if properly designed) may be more cost-effective than demand-side programs, which must identify recipients, manage claims, etc. (2) Is there an adequate number of private sector providers (of the targeted services and products and in the geographic location) so that the demand-side intervention produces the benefits of increased choice and competition, making supply-side subsidy of public providers less attractive? If effective population targeting is feasible, then the policy goals of equity and access can be met with demand-side financing, if there is at least one provider available. If there is a sufficiently large number of providers, then the policy goals of choice, efficiency, and quality can be met.

Step 3: Determine form of subsidy – restricted or unrestricted transfer. If a demand-side subsidy program is determined to be appropriate, then it is worthwhile to consider the alternatives of an unrestricted cash transfer or a restricted transfer, such as vouchers. Economic theory suggests that unrestricted cash transfers are preferable, as they are welfare enhancing compared to restricted transfers. However, there are multiple reasons to restrict what the consumer buys and/or what the provider supplies: perceived social value of the health service that needs to be promoted, low confidence that the target population will use the cash transfer for the specified service, corruption, fraud, and others. The local context will decide whether a cash transfer or a voucher mechanism is appropriate.

Step 4: Determine feasibility of a voucher mechanism. It is imperative to assess the feasibility of a voucher program before it is initiated and designed. Issues to consider include:

- Social and legal feasibility. Do social, cultural, legal, or regulatory impediments to a voucher program exist? A program must comply with social and legal norms.
- Financial feasibility. Is there funding to cover the cost of a voucher program? This necessitates a detailed cost study that estimates the costs of implementation, management, monitoring, and reporting, in addition to the cost of the consumer subsidy itself. Note that a voucher program may have high implementation costs given the costs of identifying voucher recipients, distributing vouchers, BCC, IEC, processing reimbursements to providers, and M&E.
- Technical feasibility. Are there quality health care providers available and willing to participate in a voucher program? An analysis of providers, including a survey of facilities, should be conducted to determine this. If the number of providers proves to be more limited than expected, a public tender might be used to identify providers that meet program price and quality standards. Is there capacity in the country to manage a voucher program, distribute vouchers, process reimbursements, and monitor the program? Implementing a voucher program is not feasible without this.

Once it is determined that a voucher intervention is both appropriate and feasible, policymakers can proceed to secure funding for it and design and implement it. Key elements of design and implementation are discussed in Section 5.

5. WHAT ARE KEY ELEMENTS OF DESIGNING AND IMPLEMENTING A VOUCHER PROGRAM?

Once the aims of a voucher program have been established and the scheme is found to be feasible given the local context, the next step is to design and implement the program. Key elements of design, implementation, and monitoring and evaluation are given below. (A more detailed discussion is in World Bank 2005.)

Designing a Voucher Program

Program design determines the component policies that will govern the voucher program. Who will work on each component will vary. The entity that first conceptualizes and funds the

program (as noted above, a government, a donor, etc.) may do much of the design, and then hire the voucher management agency for implementation. Alternatively, the funding agency and VMA may collaborate on design.

- Select a VMA. The VMA must have the capacity to administer the voucher program – identify voucher recipients, produce the vouchers, negotiate contracts with service providers, reimburse providers and do M&E. It is important to ensure that the selected voucher agency is neutral and does not have links to potential service providers. It must also be well respected by the community. Entities that have served as VMAs in different programs have ranged from autonomous nongovernmental organizations to university programs and governmental agencies, including ministries of health.
- Define recipient policies. The voucher scheme must identify the voucher recipients. Groups can be defined in a number of ways including geographic area (such as urban slums), occupation, age, ethnicity, gender, and income. When deciding on eligibility criteria, it is important to also consider how the criteria will be applied to identify recipients. For example, how will income be verified? It is often difficult to identify the income of poor persons because they are not formally employed and/or do not have documented income such as pay stubs. Here, an alternative would be to use another socio-economic indicator, such as asset ownership or type of housing, for determining eligibility. Another important recipient policy is transferability, that is, can the voucher be redeemed by someone other than the person to whom it was issued?
- Define benefit policies. An effective voucher program has a well-defined package of benefits for which there is a recognized need, which provides clear value to the patient, and which can be delivered by quality providers. However, when defining the benefits package, designers must simultaneously consider its implications for cost and health outcomes as well as the availability of quality providers to deliver the care (based on the provider analysis carried out in the feasibility phase).
- Define price policies. Understanding the target population's economic incentives to obtain the service or product covered by the voucher is critical when pricing the voucher. If vouchers are priced too low, the opportunity to capture additional ability to pay may be missed, and leakage may become a concern. If vouchers are priced too high, they may not be used. The voucher should clearly state the price, that is, how much is to be paid for each benefit, and to whom it should be paid.
- Define provider policies. These policies establish eligibility criteria for participation in the voucher program of providers who can deliver the covered benefits in a way that ensures quality. To be effective, policies should be defined after consultation with providers identified in the feasibility phase. Provider policies should at the very least set minimum participation standards in terms of requirements such as operating hours, staffing levels, average patient waiting times, reimbursement policies, record-keeping, and frequency of communication with the VMA. Provider policies can be leveraged to achieve various policy goals: If expanding access is the primary policy goal, then a liberal approach to contracting providers can help extend coverage. However, if quality is the primary goal, then a conservative provider policy – where the voucher program contracts only high-performing providers – is most appropriate. Provider training may have to be part of the program in order to enhance and maintain quality. Some voucher programs have used existing networks of providers, often those belonging to a private franchise, who already have quality assurance and training requirements.
- Develop BCC and IEC protocols. As discussed earlier, to ensure that recipients will use the vouchers, it is important to communicate to them: (1) what the voucher program is; (2) how the program works; and, (3) how they will benefit health-wise and financially from the

health subsidized service or product. This is especially important when cultural traditions deter utilization. BCC and IEC messages to address these points should be developed and modified as needed by the program.

- Design voucher. After overall policies are agreed upon, the voucher itself must be created. The voucher should have an attractive design, and clearly state the relevant policies (the package of benefits to which the recipient is entitled, where it can be redeemed, etc.) and expiration date. It should have sections where recipient data can be entered at the time of distribution, and verified at redemption. The voucher should also have features to prevent counterfeiting. Figure 3 shows the design used by KfW's voucher pilot program in Uganda.

Figure 3: Voucher design in KfW's Uganda pilot scheme

- Design program information system. In order to effectively monitor a voucher program and understand its impact, a strong system for data collection, processing, and analysis should be developed. Components of the information system must be developed at the design phase, such as forms to collect data on voucher distributors, recipients, providers, and clinical records. Attention should be paid to confidentiality of patient records and steps should be taken to protect the identity of voucher recipients.

Implementing a Voucher Program

Good design, discussed above, will help ensure smooth and efficient implementation of the voucher program. Some key elements of implementation are outlined here.

- Contracting with service providers. Potential providers for the voucher program should have been identified in the feasibility phase and criteria for their participation established in the design phase. In the implementation phase, requirements for operating standards, quality, training, etc. are negotiated with providers and contracts containing these provisions are executed.
- Identifying and training voucher distributors. Voucher distributors play an important role in identifying target recipients, explaining the voucher program, and then distributing the vouchers. If possible, community members or those who know the community should serve as distributors. Their training should be an ongoing activity based on the needs of the voucher program.
- Piloting a voucher program. All the country examples described in Section 4 were first implemented as pilot programs. Pilots provide information for finalizing program design, understanding program effectiveness, and assessing prospects of program sustainability and scale-up. Pilot programs should be flexible enough to change and adopt new strategies based on ongoing monitoring. Final pilot results should be assessed to see what worked and what did not.
- Institutionalizing a voucher program. For a voucher program to be sustainable, it must be institutionalized. Agencies and processes involved will vary from country to country and thus the local capacity should be assessed and understood at an early stage. Discussions with key stakeholders should also start early to ensure that institutionalization is feasible.
- Scaling up a voucher program. Once a program is shown to be effective (based on M&E), scale-up should be planned, incorporating lessons learned from the pilot program. Scale-up to serve a large population will often be the only way to show significant health impacts and achieve program efficiency, since fixed administrative costs are spread over a larger number of vouchers. Monitoring should ensure that administrative costs are not unnecessarily increased during scale-up.

Monitoring and Evaluating a Voucher Program

Planning the M&E activities of a voucher program should start at the design phase, to determine which aspects of the program need to be monitored and evaluated, and in what frequency. This enables elements of the information system (data collection forms, etc.) to be designed appropriately. A list of key areas that need M&E appears below. (World Bank 2005 provides more detail):

- Costs
- Health outcomes and impacts
- Socio-economic impacts, including impact on equity and poverty reduction
- Characteristics of voucher recipients and redeemers
- Service and product quality
- Competition between providers
- Fraud/abuse of the voucher scheme

6. CONCLUSIONS AND RECOMMENDATIONS

Demand-side financing or output-based aid programs for health care have recently gained the attention of the health care sector, donors, and country governments. This is driven by the limited success of supply-side financing and health reforms in improving service delivery as well as by the increased role of the private sector in delivering health care, even to the poorer segments of the population. Vouchers are one form of demand-side financing; they have the potential to increase use of priority health services by target populations, engage the private sector, increase competition, and improve quality of service by providers.

Experience with vouchers for health care is limited, and results based on M&E studies even more scarce. The programs seem to have met with varying levels of success, with some programs not reaching target populations due to lack of effective design and implementation. Nevertheless, the programs provide some valuable lessons.

A new voucher program should start with a feasibility study and a well-designed pilot program with a strong M&E component, so that early impacts can be documented to inform potential scale-up and results shared for future health care planning. It is important to assess during the feasibility phase whether a voucher program is the best way to reach health care policy goals, particularly given the high management and administrative costs of such a program. It also is important to bear in mind that voucher programs address financial barriers to access to care – they do not address other barriers to access, such as cultural practices or taboos. If cultural practices impede utilization of the health service of interest, other efforts to increase utilization, like BCC, are needed.

Once found feasible, emphasis must be paid to initial design. Voucher programs need to have clear policies on pricing, benefits, recipients, and providers so that there will be high uptake of vouchers and the vouchers will in fact be redeemed by the target recipients. Once implementation begins, monitoring must be continuous, so that program design can be adjusted as needed for greatest impact. Lessons learned from existing programs suggest that significant IEC campaigns must be continued to maintain recipient awareness and high uptake of vouchers throughout the life of the program.

Vouchers provide a promising option for increasing utilization of priority health services by subsidizing target population groups directly. There is a clear need to build a strong evidence base and room for well-designed voucher pilot programs to demonstrate best practices for effectiveness. Several new pilot programs, including ones funded by USAID in India and KfW in India, Kenya, and Uganda, promise valuable insights.

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About PSP-*One*

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