



AFRICAN STRATEGIES FOR HEALTH



Photo by Raul Pires

**COST-EFFECTIVENESS
OF REPRODUCTIVE
HEALTH VOUCHERS AND
COMMUNITY-BASED HEALTH
INSURANCE IN UGANDA**

Background

Underutilization of maternal health services slows progress toward reducing maternal and neonatal morbidity and mortality. In Uganda, almost 18% of deaths of women aged 15–49 are maternal. The Uganda 2011 Demographic and Health Survey indicates low utilization of maternal care: 52% of pregnant women do not make four or more antenatal care visits during

their pregnancy; 42% of births are not assisted by a skilled health provider; and 43% of births were not delivered at health facilities.¹ To enhance the use and provision of quality maternal care, donors and recipient country governments are increasingly looking to remove barriers to health care-seeking by incentivizing quality care through the use of economic subsidies. When planned and used appropriately, financial incentives can effectively improve utilization and quality of maternal and neonatal care.²

Demand-side financing, such as the use of vouchers, offers a direct link between the subsidy for the intended beneficiary and the desired output. Greater levels of pooled prepaid funds and broader health coverage, as with community-based health insurance (CBHI), can lead to improved access to care and lower mortality.³ Both of these schemes offer ways to minimize out-of-pocket charges for facility-based services and encourage appropriate targeting of services to the poor.

Reproductive health vouchers (RHVs) and CBHI schemes currently operate at varying scales in Uganda. The Uganda Reproductive Health Voucher (RHV) program started in 2006, was financed by the German Development Bank (KfW) and the World Bank through the Global Partnership on Output-Based Aid (GPOBA). Eligible pregnant women purchased a voucher for a subsidized fee of US\$1.40 from an accredited voucher service provider; covering four antenatal care visits, delivery care, referral and treatment of eventual complications, and a postnatal care visit. Out of the 50,000 RHVs sold in Uganda in 2011, 40,000 were

ABOUT ASH

African Strategies for Health (ASH) is a five-year project funded by the U.S. Agency for International Development's (USAID) Bureau for Africa and implemented by Management Sciences for Health. ASH works to improve the health status of populations across Africa through identifying and advocating for best practices, enhancing technical capacity, and engaging African regional institutions to address health issues in a sustainable manner. ASH provides information on trends and developments on the continent to USAID and other development partners to enhance decision-making regarding investments in health.

redeemed for delivery. A detailed study of a voucher program from Western Uganda found that the rate of facility-based deliveries among RHV recipients was 9.4 percentage points higher than among those without RHVs.⁴ However, enrollment in health insurance is relatively low; less than 2% of the population was enrolled in 2011.¹ Most of the participating service providers are private nonprofit organizations that partially subsidize the cost of CBHI for clients through ongoing donor subsidies.

To understand better the feasibility and impact of economic subsidies in increasing utilization of maternal health services for women of reproductive age (WRA) in Uganda, USAID commissioned ASH to undertake a study examining the cost-effectiveness of RHVs and subsidized CBHI programs.* The study examined the Uganda RHV Program and the following CBHI schemes: Medical Insurance for Low Income (MILO), Saving for Health Uganda (SHU), and health care cooperatives (coops). This brief presents key findings and recommendations of relevance to policymakers and program managers.

Methodology

Utilization and cost data for each financing scheme was collected via desk reviews, structured interviews, and field observations from site visits in Bushenyi and Mbarara districts in Western Uganda and health maintenance organizations (HMOs) in Kampala. The impact of both financing strategies was modeled through the increase in facility-based deliveries averting disability-adjusted life years (DALYs).

Findings & Recommendations

Both RHVs and CBHI schemes are highly cost-effective at \$302 and \$298 per DALY averted, respectively, since they are less than Uganda's per capita gross domestic product (GDP) of \$510 per capita. According to the World Health Organization, a service is considered highly cost-effective if it can generate a DALY at a cost below the country's GDP per capita. Both schemes can co-exist in settings where voucher schemes identify the lowest income households and subsidize their premiums, while the CBHI scheme pays providers for delivering services to all insured beneficiaries.

1. As with RHVs, subsidized CBHI schemes should include outreach to encourage poor women to deliver at health facilities, transportation to and from health centers for deliveries, and incentives to health workers for increased volume and improved quality of health services.
2. Since RHVs and CBHI schemes both ensure adequate targeting of public health expenditures to vulnerable groups through sliding-scale fees or premiums, policymakers can use these strategies to accelerate the equity goals of universal health coverage.

* ASH collaborated with a team of authors from USAID/Uganda, Makerere University (Uganda), Mzumbe University (Tanzania), and Brandeis University (USA).

3. RHVs and subsidized CBHI schemes can be used to finance nongovernment, government, and private-for-profit facilities and transportation to facilities in order to extend the reach of services.
4. Administrative costs associated with subsidized CBHI schemes and RHVs can be lowered by using local organizations for programmatic and financial management and regulation.
5. Incorporation of specific quality reviews and audits managed by the voucher management or CBHI agency, and introduction of results-based financing alongside CBHI has the potential to result in improvements to the quality of facilities.
6. Local health sector leadership and the beneficiary population should be jointly involved in the management, design, and operations of RHVs and CBHI schemes in order to make them programmatically and financially sustainable.
7. Examination of CBHI schemes and RHVs should be expanded with an experimental design to accurately measure costs, utilization, and outcomes.

Conclusion

RHVs and CBHI schemes have proven useful in Uganda and elsewhere in contributing to improved access and quality of maternal health services. Both RHVs and CBHI schemes are highly cost-effective and consistent with the broader policy of universal health coverage under the provision of a benefits package supported by the East African Community. They are also consistent with Uganda's Health Sector Strategic and Investment Plan and USAID's Maternal Health Vision for Action. The recommendations outlined above may be effective in expanding the reach and impact of RHVs and CBHI among WRA. Translating these recommendations into practice is critical for ensuring that WRA are able to access quality and affordable care at health facilities. ■

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