Reproductive Health Voucher Schemes in Uganda: Key Lessons for the Future

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Introduction

Uganda has a mixed health system of both public and private facilities. The public health system is designed to provide equitable access to essential services. However, a lack of adequate funding to the health sector has limited its ability to ensure that services are always available. Approximately half of Uganda’s facilities are private and charge service fees which create access barriers for the poor. Uganda’s population is growing quickly, and recent data suggest poverty rates have started rising. While there have been improvements in both family planning (FP) and maternal, newborn, and child health (MNCH) indicators, the poor do not comprise a significant proportion of that improvement.

Voucher schemes are one approach Uganda has used for more than a decade to improve access by the poor to FP and MNCH services. The latest two voucher initiatives were the Uganda Voucher Plus Activity (UVPA) and the Uganda Reproductive Health Voucher Project (URHVP-II). Both started in 2016, covered approximately half of the country, and shared many design features. The URHVP-II was completed in December 2019 and the UVPA in September 2020.

The URHVP-II was a five-year MOH project financed by grants from the World Bank led Global Partnership on Output Based Aid and the United Nations Population Fund for USD $17.3 million. Implemented by Marie Stopes Uganda, the project built on an initial pilot in the Southwest region and was expanded to high-need areas in the Eastern region.

The UVPA was financed by the United States Agency for International Development through a five-year USD $24.5 million project awarded to Abt Associates who led a consortium of partners which implemented the activity. Focused in the Northern and Eastern regions of the country, catchment districts were chosen to avoid overlaps with URHVP-II and contribute to national voucher coverage.

In early 2020, ThinkWell and the Uganda Ministry of Health (MOH) collaborated to study the UVPA and URHVP-II voucher experiences. The purpose of this effort was to capture what had been achieved by the voucher schemes and distill what could be taken forward to future health system purchasing reforms. The full report documents the findings and steps forward.

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Methods

**Objective:** Document the functional designs of the UVPA and URHVP-II voucher schemes, analyze their performance, consider lessons learned, and identify steps forward for health purchasing reforms.

**Document Review:** The desk review focused on literature related to Uganda and voucher experiences in the country. Relevant contextual literature and data was sourced from the MOH, the Uganda Bureau of Statistics, and the Office of the Auditor General.

Both the UVPA and the URHVP-II projects made extensive project documentation available, including work plans, standard operating procedures, technical briefs, as well as quarterly and annual reports.

Key senior staff at both Marie Stopes Uganda and Abt Associates sat for interviews to describe their work, providing insights and clarity to project documentation.

**Quantitative Data:** Both projects provided access to raw operational data from the Voucher Management Information System used by both projects. This anonymized record-based data covered financial, utilization, and quality measurements that allowed the independent analysis by the study team.

**Key Informant Interviews:** Conducted key informant interviews with relevant stakeholders associated with both projects, including representatives from the MOH, the World Bank, USAID, faith-based medical bureaus, and the Uganda Healthcare Federation.

**Focus Group Discussions:** Conducted focus group discussions with district health authorities, voucher service providers, and voucher distributors. A purposive sampling process was employed to ensure the broadest possible range of experiences and opinions.

Interviews planned to last approximately an hour often went for 2-3 hours with the standardized discussion questions generating lively and intense contributions.

**Limitations:** Starting in March 2020, the Government of Uganda instituted large-scale shutdowns due to COVID-19. This prevented the completion of planned field-level interviews with senior MOH officials.

**Data analysis:** All interviews were recorded (with consent), transcribed, coded (with cross-coder verification), and analyzed using the Dedoose software package for shared insights and illustrative quotes. The research team analyzed the quantitative operational data provided by both the UVPA and URHVP-II projects to generate the relevant figures and graphs presented in this study.

**Relevance:** Despite the limitations presented by COVID-19, this study collected and analyzed a significant amount of literature, quantitative, and qualitative data that revealing insights into the operations the voucher schemes. Lessons learned on the practicalities of a large-scale demand side purchasing mechanism support identified steps forward.
Implementation Structures: The Ugandan health system uses a supply-side financed integrated service delivery model. In pursuit of improved performance, the MOH has embraced output-based financing approaches that include reproductive voucher schemes. The UVPA and URHVP-II schemes used Voucher Management Agencies (VMAs) as independent purchasers that selectively contracted public, not-for-profit, and private providers. A national coordination mechanism was initially established at the MOH level for both voucher projects, but its utility was limited.

Benefits Package: With a focus on primary health care, the MOH established the Uganda National Minimum Health Care Package (UNMHCP), which guides service delivery; however, availability of key services is often a challenge due to inadequate funding of the sector. In response to access barriers for poor women in rural areas, the voucher projects defined a benefits package of prioritized FP and MNCH services that included 4 ANC visits, safe delivery, 2 PNC visits, and postpartum FP.

Demand Creation: Uganda does not currently have a national approach to poverty targeting. In this context, voucher schemes undertook large efforts to generate demand through community mobilization. They engaged voucher distributors to conduct poverty assessments that identified rural poor pregnant women, qualifying them to purchase a voucher at the subsidized price of approximately $1.00 and entitling them to the full voucher benefit package at a contracted VSP near their home.

Contracting Health Service Providers: Selective contracting of VSPs was based on pre-assessments of potential BEmONC and CEmONC* facilities to establish referral networks. VSPs were predominantly private and not-for-profit facilities. Private wings in high-level public facilities were also contracted. Contracts with VSPs clearly defined reimbursable services, provider payment rates, quality standards, and penalties for fraud.

Quality Assurance: The MOH Quality Assurance Program developed a facility quality assessment tool as part of its overall facility-centered quality improvement model. The UVPA and URHVP-II voucher schemes used the MOH facility assessment tool, augmented by Marie Stopes International, to measure quality, but opted for an external mentorship-based approach to quality improvement.

Claims Management: Based on an integrated service delivery model, the public health system (mostly) does not include (or need) a claims management process as part of how it pays its providers. Notable exceptions include the modified ‘pull’ system of the National Medical Stores and the invoice-based claim system of the national PBF mechanism. As both voucher projects mainly contracted with private facilities, they established robust claims management systems that controlled for fraud. In this system, VSPs proved highly capable of submitting timely claims for payment. A major challenge was significant delays in providers getting paid due to the heavy administrative burden of these systems. Following COVID-19 lockdowns, partial pre-payment of VSPs was successfully implemented.

Performance of the Voucher Programs

- Combined, both projects supported nearly 400,000 women to access to safe delivery services.
- Voucher redemption rates were high, and respondents generally agreed that the voucher benefits package was well designed.
- Utilization rates of postpartum FP were relatively low.
- Quality improvement efforts by both projects successfully raised assessment scores, driven by provider investments from their voucher revenues.
- Both projects experienced and overcame significant delays making provider payments due to challenges with claims management.
- Cascade analysis revealed significant drops in the continuum of care at each stage, particularly from delivery to postnatal care and postpartum FP.
Lessons Learned

✓ The voucher benefits package brought focus to FP and MNCH services. The voucher schemes effectively extended access to FP and MNCH services by rural poor pregnant women by combining poverty targeting, demand creation, quality improvement efforts, and performance management of providers.

✓ The voucher projects created dynamic service delivery networks. By contracting all types of facilities, private and public, the voucher schemes established flexible networks of providers to serve poor, hard-to-reach populations. A fundamental design limitation was that voucher schemes could not work in areas with no providers.

✓ Contracted providers improved their capacity and performance while being held accountable. Being paid fair rates for the services they provided, providers had the necessary resources and autonomy to ensure the availability of services to meet demand.

✓ Provider investments drove quality improvements. With strict contract obligations and project-supported mentoring, contracted voucher service providers improved their capacity and quality of care by investing their voucher revenues back into their facilities.

✓ Contract-based purchase of services requires that significant levels of administrative capacity. Claim management systems are an essential part of ensuring transparency and accountability. Claim submission issues from providers or slow review processes by the purchaser can delay provider payments and interrupt service delivery, eroding trust in the system.

✓ There were concerns that voucher projects were too expensive. While the projects’ overhead costs were high, they included the investments required to startup a demand-side purchasing mechanism. Absent the investment costs, the recurring administrative costs of a government-managed demand-side purchasing mechanism would likely be lower.

Steps Forward

➢ Continue efforts to establish a government-financed demand-side purchasing mechanism. As an enhancement to the financing of the public health system, demand-side purchase of services from providers of all types (public, non-profit, and private) can support the realization of coordinated service delivery across the health sector to achieve health system goals.

➢ Plan to progressively realize a comprehensive benefits package by starting with a focus on FP and MNCH services. Recognizing that the start-up of a new demand-side purchasing mechanism requires intensive effort to establish and refine the critical systems, an initial benefits package of FP and MNCH services are an excellent place to start.

➢ Explore cost-efficient modalities to purchase services from private facilities. By paying fair evidenced-based rates for well-defined services, a purchasing mechanism can engage private facilities to extend publicly financed services that meet government quality standards.

➢ Explore design options for claims management systems that prevent provider payment delays. Providers can be safely paid a portion of their submitted invoices before the full vetting of their claim details. Problems found can be resolved through deductions or penalties applied to their remaining or future payments.