

INSTITUTIONAL ISSUES IN SCALING UP PROGRAMMES FOR MEETING THE
HEALTH RELATED NEEDS OF THE VERY POOR

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Aim of the Paper

To examine the different approaches taken by different agencies for expanding and extending those initiatives shown to effectively meet the needs of the very poor in order to cover a larger population group.

Introduction

Two main bodies of research and documentation are relevant to this paper. The first is conceptual and methodological. The work of the Development Research Centre on Chronic Poverty (DRCCP) has analysed the complex gradations of poverty, or socio-economic rungs, through which people can ascend or descend. This body of work breaks down the category of the poor, indicating the very significant differences in consumption and living standards within the category (Smith and Subbarao, 2002). Of particular relevance to health policy is the implication in some of this work of a correlation between poor households experiencing health-related shocks and their descent into extremely vulnerable / chronically poor groupings (Amis 2002, Kassie 2000). As Ravallion notes, 'increasingly, uninsured risk is coming to be seen as a cause of chronic poverty' (2003:10).

The proxy indicators of 'chronic poverty' identified in DRCCP papers are summarised by Bloom (2004:1) as being:

- certain geographic locations such as remote rural areas, urban slums and conflict zones (Amis 2002; Bird et al 2002)
- certain disadvantaged social groups such as castes, tribes, ethnic groups, refugees and so forth (Okidi and Mugambe 2002; Mehta and Shah 2002)
- disadvantaged people in households such as elderly, disabled, women, children (Heslop and Gorman 2002; Yeo 2001)
- poor health (disability, serious illness)
- life cycle (elderly, children, widows)
- economic position (bonded or indentured labour)

An important implication of this classification is that programmes aimed at improving the health of the very poor need to be similarly differentiated in terms of institutional arrangements and capacity to reach these diverse groups. A "one size fits all" approach to scaling up for the very poor will not work either.

Second, there is a large body of documentation indicating that standard models of state-provided health services in both low and middle-income countries tend to result in wealthier income groups receiving a disproportionate share of public health spending at the expense of poor and vulnerable sectors of the population¹. The very poor and vulnerable are widely acknowledged to be the most intractable to reach through mainstream sectoral policies and programmes. This is widely accepted to prevail 'for a variety of reasons including physical proximity to facilities, leakage of resources away from diseases proliferating amongst the poorest, ignorance of treatment options and cultural and household constraints' (Ensor, 2003:12). We can add to this, high levels of resort to self-treatment and unregulated health markets among the very poor as public facilities fail to provide appropriate services to these groups.

¹ Cf: Gwatkin (2003) 'In brief, even the simplest interventions offered through government facilities usually reach the better off at least somewhat more frequently than they do the neediest' (p3) and 'In Africa...the top twenty percent of the population gets two and a half times as much benefit from government health expenditure as does the bottom twenty percent (p8)'. Cf: also Ensor (2003:5) and Rannan-Eliya cited in McNay, K *et al* (2004:16).

Both sets of studies find that health systems have significant ground to travel in meeting the needs of the poorest. However, there is relatively little published or grey material on successful institutional scaling up of health programmes geared to these groups. There is somewhat more learning from outside the health sector from potentially scaleable experiments through food and cash transfers to the poorest sectors of the population at regional or national levels .

1. What institutional arrangements have organisations put in place to ensure that expanded programmes continue to reach the very poorest?

The main approach to this is through targeted interventions. This section will focus mainly on targeting mechanisms and the institutional issues they raise.

Mechanisms used to disperse public services can be roughly divided into those aiming to provide on a universal basis, and those seeking to restrict a benefit or service to a sub-set of the population through the use of some sort of targeting mechanism or targeted transfer². As the ability of universal models to equitably dispense benefits to a population is being increasingly questioned, targeting is enjoying a renewed popularity in mainstream development thinking as the most effective way to reach vulnerable groups³.

This paper is mainly concerned, therefore, with targeted dispersal systems as it is here that the most potential for learning appears to be found. As a range of possible targeting mechanisms exist, each with advantages and drawbacks that carry significant implications for the institutional requirements and scale-up capacity of the intervention, the different available mechanisms are outlined below.

Key-terms: targeting and targeting mechanisms

Targeting mechanisms take a number of different forms:

Direct or individual targeting refers to a system that performs means-testing of beneficiaries, enabling administrators to directly ascertain the relative wealth (or poverty) of a household (Gwatkin, 2003:4). Due to the high administrative requirements of such a system and paucity of reliable data about citizens, the use of such targeting in Least Developed Countries (LDCs) is often impractical and expensive (Barrett and Clay, 2001:2)⁴. **Indicator targeting** therefore, has often been employed as an alternative. This uses certain agreed characteristics (such as location of residence, level of land ownership, age, etc) to identify those most in need in a community (Ravallion, 2003:17). While far less complex administratively than direct targeting, one significant drawback of this approach is its potential for error, due to the diversity of consumption levels that often exists among those displaying

² This can be in cash or kind. The majority of cash transfers are conditional – i.e. they can only be converted into a specific good or service

³ Ravallion observes that ‘conventional wisdom in mainstream development policy circles’ which has for a long time discounted targeting mechanisms on account of i) the leakage of benefits to the non-poor and ii) their perverse impact on labour-supply and savings of recipients, is now being fundamentally questioned, if not discounted (2003:1-2).

⁴ Gwatkin notes that within health, one particular type of individual targeting has tended to receive the most attention, that of identifying poor individuals who qualify for exemption from health system user fees (2003:5). While Thailand has encountered some success with this model (*ibid*:6), it is generally seen as a poor way to target: ‘Exemptions from fees are unlikely to direct...subsidies precisely, while provider incentives are weak and distorted’ (Islam, 2004:16).

outwardly similar characteristics⁵. This is a major issue for the health sector, where targeting, optimally, needs to take account of health needs at a household and individual level. Alternative ways of dealing with this in the health sector are through burden of disease analysis (conditions which particularly affect the poor) and interventions focused on easily discernible conditions, such as pregnancy.

Community-based targeting and **self-targeting** provide alternative means to identify those most in need. In the former, decisions are usually taken by the programme's central administration (national or subnational) on the amount of public good to be distributed to each locality, while distribution within the locality becomes the job of some local authority. This model seeks to exploit informational advantages of local knowledge. However, two primary concerns remain: firstly, the potential for capture of benefits by local elites due to the degree of discretion afforded them, and secondly, the likelihood that the experience and results of usage of community-based targeting are likely to be as diverse, and thus as non-predictable, as the communities themselves (Ravallion, 2003:21)⁶.

Self-targeting, requires no administrative selection at all, but rests on making a public good available on terms that are attractive only to the very poor. Food-for-Work programmes are the best publicised examples making effective use of this mechanism (Barrett and Clay, 2001:3-4). Within the health sector, examples would include a system that made PHC services freely available to the self-selecting poorest but that imposed inconvenience upon users, such as significant queuing for services, that would give sufficient incentive to those with the capacity to pay for services to do so (Alderman in Ravallion, 2003: 23). An obvious potential problem with such a mechanism is that by seeking to make the costs of participation attractive only to those with no other option, the costs of participation also effectively bar those for whom the service is intended (Ravallion: 2003:23).

There is another, indirect, way in which self-targeting works in the health sector, namely through market segmentation. One of the key features of Sri Lanka's success in creating a relatively pro-poor health system is through a form of self-targeting. The private sector mainly provides outpatient care to the wealthier, enabling them to select out of the public sector in response to the private sector's better waiting times and less over-crowding. The public sector meanwhile retains a monopoly on in-patient services and on out-patient services for the poorer, through differentials in consumer perceived quality (SCF: 16-9).

A two-tier system can be prevented from developing by ensuring that technical quality in public sector remains equal to that of the private market, by for instance, training the majority of providers in the public system thus ensuring that professional reputations must be made, and kept, in this sector but allowing part-time private practice. Latin America is one of the few regions to show a similarly pro-poor bias of expenditure due to self-exclusion of the wealthier from certain services (Gwatkin: 4). However, we have little direct evidence on the extent to which the very poor and vulnerable groups are actually catered for in these relatively pro-poor health systems

⁵Note also that in the cases of both direct and indicator targeting, once the purpose of data collection is clear, there will be incentives for households to distort it to exaggerate their hallmarks of poverty (Ravallion, 2003:17).

⁶Galasso and Ravallion, researching Bangladesh's Food For Education project, found that the higher the levels of inequity of land ownership in a village, the worse that village performed at community-based targeting of the poor, suggesting the perpetuation of inequity where the poor are economically weakest (

Where programmes are targeted, what mechanisms are used, and how accurate and cost-effective are they?

The recent World Bank Conference on Local Development, (Washington DC 2004) provided useful insights on institutional and scaling up questions in targeted interventions.

Targeting and reaching the poorest

The administrative challenges which targeting presents to LDCs are reflected in a review of World Bank support to vulnerable group programmes. This finds that 'most vulnerable' programmes have a heavy bias towards the Latin American region (Gibbons, 2004: 6), suggesting that targeted programmes are more likely to emerge in areas with more sophisticated administrative infrastructure and to be most appropriate institutionally to middle income countries.

Despite their imperfections however, targeted programmes are widely held to be more effective generally at reaching the poor than those that are untargeted, and this is confirmed by the recent comprehensive World Bank review comparing targeted against untargeted initiatives (covering 67 programmes from different sectors).⁷

Geographical targeting

The World Bank review found geographical targeting to be effective for reaching certain categories of the very poor who tend to be geographically concentrated – such as ethnic groups and war-affected populations (Gibbons, 2004:14)⁸.

However, in the absence of sophisticated data gathering systems to map the necessary demographics, defining proxy indicators for geographical targeting remains an imperfect technique: one example of the problems inherent in this method is provided by the Malawi Social Action Fund (MASAF) evaluation: 'The experience of MASAF illustrated the difficulties that a scaled-up public works programme would face. There were disputes about the appropriateness of the indicators of a geographical area's need. These indicators would have to be updated frequently to command general support' (Bloom et al, 2004:2).

From a health perspective, geographical targeting is most relevant a) to contexts where particular types of poverty or vulnerability are known to be spatially highly concentrated, and b) where there are clear challenges from high levels of diseases which disproportionately affect the poorest.

Targeting to mitigate social exclusion

Language-based targeting through tailored local language promotional campaigns have been used to identify beneficiaries where ethnic / minority communities are targeted recipients (Gibbons, 2004:17). The Slovak Social Fund (successfully) used employment-based targeting to engage the marginalised Roma population in its

⁷This review 'found that the poor got more benefits in 70-75 per cent of cases than they would have, had the benefits been evenly distributed across the population (which would in itself be an improvement over the present situation with respect to government health service expenditure programs)' (Gwatkin, 2002:5).

⁸ However, as the poverty of certain ethnic populations can be linked to their more general social exclusion, the 'vulnerable group' review report recommended the avoidance of long-term targeting for these categories of the very poor, as it may have the effect of further marginalising / creating ghettos (Gibbons, 2004: 25).

activities in part through the hiring of staff representatives of this group, and ensuring Slovak representation on steering committees (WB 2004b:1)

Example: BRAC's use of community-based targeting

In Bangladesh, the IGVD programme aims to reach the most vulnerable groups in the community.⁹ It employs a community-based targeting principle in which the overall allocation of benefits to localities is administered at the centre¹⁰, and allocation to individual households is mediated by elected representatives of unions and wards¹¹. Independent assessment of targeting found a minimal amount of leakage to the non-poor: 'on a set of extreme-poor sensitive indicators, the IGVD fares quite well' (Hashemi cited in Matin, 2002:17). While no figures of the cost of targeting are available, the use of elected representatives to dispense participation in the scheme to participants would imply this element of targeting administration was on a voluntary basis. Thus the costs of the mechanism could be expected to be minimal.

While this is highly encouraging, the community-based targeting mechanism, revealed deficiencies arising from the clientelist nature of socio-political power in Bangladesh. While the targeting mechanism efficiently disabled those outside of intended beneficiary groups receiving benefits, thus leakage levels were low, there appears to have been a lack of equity of selection *among* those in such beneficiary categories. Using local elites to select qualified participants appears to have construed eligibility in favour of the chronically poor who were connected in some way to those elites (through seasonal agricultural employment, or use as election hands) and this group of poor candidates were revealed to enjoy increased chances of receiving repeat benefits through the scheme while a significant percentage of chronically poor households appear to have been excluded from consideration (Matin: 2001: 15-19). Such a finding indicates that closer monitoring and mechanisms for remedial action to ensure equitable distribution of benefits may be needed for programmes employing community-based targeting mechanisms.

In what contexts should targeting not be tried?

Where the majority of the population in an area needs a service, and a non-existent or poor quality private sector exists, then establishment of a targeting mechanism and associated infrastructure may be an expensive, and possibly inequitable, remedy for the situation (Ensor, 2003:12).

Targeting the very poorest

The most effective forms of targeting combine different modalities, for instance a first level geographical mapping by district or other administrative unit, combined with selective targeting on household or other criteria. This is complex and also requires data to be both available and reasonably accurate and therefore has to be offset against what is possible and cost effective. There is also likely to be a difference in capacity between, for instance, urban and rural areas. Backing health interventions onto existing targeted poverty reduction programmes is one way of dealing with this. There is considerable potential for doing this in countries such as India and Bangladesh with a fairly developed infrastructure of poverty interventions. Where

⁹ The programme seeks to reach i) the 'chronically poor', described as those who frequently go without food; ii) 'widows and young women with children abandoned by their husbands' as well as iii) 'occasionally deficit' households who have recently suffered a major shock usually to the male head of household (Matin, 2002:14). Category ii) therefore falls within the indicators used by the DRCCP outlined at opening.

¹⁰ Using food insecurity and vulnerability maps (Matin, 2002: 19)

¹¹ The lowest tiers of local government machinery in Bangladesh.

existing poverty-reduction programmes operate a relatively accurate means of targeting the poorest, linking up with those programmes to make use of, and assist in the refinement of, their poverty targeting mechanisms could be the most effective and economical path to establishing a pro-poor health programme.

An example from Bangladesh is BRAC's experience is annexing a micro-credit programme for the extreme poor onto the World Food Programme's Vulnerable Group Feeding Programme. This demonstrated that adding a longer-term pro-poor intervention onto an emergency relief programme can enable an easy entry point and facilitate the refinement of a targeting mechanism over time (Matin, 2002)¹². In seeking the best entry point to the poorest groups, BRAC deliberately approached administrators of short-term emergency input programmes, with which they sought to dovetail more medium term interventions. This was in recognition of the constraints that operate against the participation of the extreme poor in longer term projects and the need therefore for facilitate strategic linkages enabling them 'to benefit from other mainstream development projects' (*ibid*:4). Developing institutional means to dovetail between relief and more permanent structures of care may well prove an efficient entry point for health service interventions seeking to target the very poor.

A second possible entry point for health interventions seeking to reach the poorest is suggested by an increasing body of analysis finding that rural work / food-for-work programmes are among the most effective in identifying those from the poorest communities¹³. The self-targeting mechanism employed by such schemes renders them simple to administer, and they are, in part consequentially, enjoying an increased uptake in LDCs..

What other institutional factors / obstacles need to be taken into account?

As many commentators have pointed out, in calculating the costs of health care to the extreme poor, indirect costs, such as transport and lost income, often impose a larger burden than the obvious expenses of paying fees for curative services and purchasing medicines. There may also be substantial social obstacles to overcome, such as stigma, and lack of voice. To truly render health care accessible to the poorest, institutional mechanisms need to consider how to minimise these costs and obstacles.

Summary

What the targeting literature shows is that there are no perfect schemes. All suffer to some degree from elements of leakage and weak institutional and governance structures. The larger the scale the more likely this is to be the case. However, in low income countries struggling with multiple constraints and challenges, this is hardly surprising. The more complex the targeting mechanisms, the greater the institutional challenges. It may be that the trade off is an agreement on what is an acceptable level of leakage. Overall, the findings seem to suggest that the distributive benefits of at least some types of targeting in the health and social sectors in developing countries outweigh the governance and administrative problems. However, this can only be definitively determined on a case by case basis and with better information on the costs of schemes of different magnitude.

¹² The accuracy of the targeting mechanism in the Income Generation for Vulnerable Group Development (IGVGD) programme has been independently assessed to be high (Matin, 2002:17), despite issues of equity of access to the programme's benefits among those in the poorest groupings (see section 4 below).

¹³ Cf: Lustig, N (1997:2), Ravallion, M (1991:6) and Barrett and Clay (2001:3).

2. What institutional arrangements have organisations put in place to ensure that expanded programmes support health services that continue to be of high quality and appropriate for the poorest?

I cannot locate any information on this. The only relevant finding is that noted under demand side financing below – that some programmes have been effective in increasing coverage but have not tackled quality constraints

Try Peter Poore?

3. To what degree do scaling up initiatives simply replicate factors that lead to the exclusion of the very poor?

Ditto – not sure what data would address this question

4. What roles have governments and non-state actors (NGOs, CBOs, faith based organisations and private sector) played in purchasing and providing services for the very poor?

There is a long history of involvement of NGOs and faith based organisations in service delivery to the poorest populations. Obvious examples are Christian mission run facilities in sub-Saharan Africa, involvement of Islamic charities in social services in a number of countries and NGO run health services – mainly at primary care level – in many low income countries. A clearer understanding of the different institutional arrangements and contracts entailed in this very wide range of relationships is beyond the scope of this paper.

(Peter Poore may be able to develop this theme through specific empirical examples??)

5. How have governments and non-state actors supported demand side aspects of meeting the health needs of the very poor?

6. How can utilisation by the poorest of health services be scaled up through demand side initiatives? For example, do initiatives that link service utilisation to cash transfers to certain groups facilitate greater use by the poorest or not?

(I have put these together as they seem to me to be the same question)

The main body of literature here comes from what has become termed “demand side financing”

Key-terms: demand-side financing (DSF)

Falling mainly under the umbrella of targeted transfer mechanisms, and generally divisible into the above categories, demand-side financing systems are increasingly engaging policy makers’ interest as potential instruments for delivering services to the poor, including the very poor¹⁴. Defined by Pearson as ‘a means of transferring purchasing power to specified groups for the purchase of defined goods and services’ (cited in Islam, 2003:20), demand-side mechanisms stand in opposition to traditional mechanisms of making inputs to health systems, where suppliers of services are given additional resources to provide services for a distinct group. By contrast, DS mechanisms aim to give the resources direct to users or to a body acting on their behalf. Third party purchasing thus has elements of demand side financing. DSF is more commonly associated with vouchers or cash transfers. These are exchanged for services from a provider, sometimes dictated or sometime of the

¹⁴ cf: Standing and Gooding, 2003: 1; Standing, 2004:4, Ensor, 2004:5; Islam 2003:6

users' choice. Institutionally, DSF requires both a targeting mechanism and an infrastructure for administering the transfers and monitoring providers and recipients.

DSF has been used more extensively in education than in health and has been particularly aimed at increasing utilisation (e.g. of school attendance by girls). In health, it is being put forward not only as a way of targeting the poor and vulnerable groups (e.g. very poor pregnant women, people with disabilities) but as way of improving the supply side response to the poor through enhanced competition between providers for clients with purchasing capacity (Standing and Gooding 2003, Ensor, 2003:5).

Experiences of DSF in health and other sectors

The most comprehensive review of demand-side financing in health and education (Ensor, 2003) found just 12 cases of DSF within health for which evaluation studies were available. These are mostly from middle or high income countries. We thus have a very small evidence base on DSF in the health sector of low income countries.

In Bangladesh, the World Bank supported Educational Stipend Programme is an example from outside the health sector of a highly successful demand-side programme in which tuition and stipends for secondary school students have been able to greatly increase numbers of girls attending school in Bangladesh (Islam, 2003:7) however, it contains mixed lessons on the possibilities of targeting the very poor. For example, resentment by the less poor of the initially targeted nature of the intervention led to an extension of the stipend scheme to other rural households. It is not clear to what extent the very poor take advantage of this programme.

Modes of DSF employed within health and targeted at specific vulnerable groups include:

- Use of a voucher / other form of evidence of entitlement ('The most common mode of DS scheme' Ensor, 2003:4)
- Group specific transfers to pregnant or nursing mothers / sex workers / young children (Standing & Gooding:2)
- Treatment entitlements for people with disabilities (*ibid*: 2)
- Cash transfers to households below poverty line conditional upon medical care being obtained (Ensor: 40)
- Community-based micro health insurance initiatives (Islam, 2003:8)
- Community-driven development schemes financed under targeted Social Funds

Cambodian Health Equity Fund

One promising application of a direct targeting mechanism able to identify the poor and administer payment of hospital costs on their behalf is provided by the Sotnikum Health Equity Fund (HEF) in Cambodia (Hardeman W *et al*: 2004). Avoiding the well-publicised failures that can arise when government health personnel are tasked with identifying and exempting poor patients from hospital fees¹⁵, the scheme engages a third party agent, here a local NGO, to identify the poorest patients and pay hospital fees on their behalf, as well as indirect costs (food, medicines and transport) direct to the patients. The scheme seeks to reach the 'extremely poor' as well as those 'at risk

¹⁵ Such failures are held to arise from health workers i) lacking the skills to objectively assess a patient's incomes and ii) experiencing a conflict of interest between giving exemptions and the pressure to maximising revenue, particularly where fees are officially intended to augment their own incomes (Hardeman *et al* 2004:22).

of falling into extreme poverty'¹⁶, and the contracted NGO used a pre-existing, field-tested questionnaire to score self-reported socio-economic status of patients entering the hospital, together with active identification of poor patients in hospital wards¹⁷ (2004:24). Independent evaluation reported greatest efficacy in identifying and assisting those in the extreme poor category, lesser efficacy in successful identification of those in the 'at risk' category, and minimal leakage to the non-poor (2004:25-26). A steep increase in the number of poor patients accessing hospital services in the second year of the scheme's operation indicates its success in facilitating access for those who would otherwise have been prevented from seeking services (2004:29). The costs of the intervention were deemed to be low, constituting 8.6% of the total annual hospital budget (2004:29) or US\$ 0.06 per capital per year (2004:29).

Institutional issues in scaling-up

In the ostensibly successful case of Cambodia's HEF, the existence of a local NGO with a pre-existing, tested mechanism for identifying the poor, together with pre-existing relations with this constituency, appear to have been a factor in its success. Similarly, the lack of widespread knowledge about the scheme was probably a factor in the accurate patient responses to self-reported socio-economic questionnaires confirmed by evaluation reports of zero leakage to non-poor patients. In seeking to scale-up the scheme, as the Cambodian government is aiming to do, obvious obstacles present themselves. Firstly, the problems of finding third-party purchasing bodies with similar capacity, experience and motivation to that of the NGO contracted in the pilot case, and the incentives for patients to distort responses to wealth assessment tools as knowledge of the scheme and its value increases among the population at large. Additionally, the Sotnikum pilot took place in a context of successful qualitative reforms being made to the service providing environment, a factor behind the high demand for government-run hospital services. Ensuring such reform in all provinces in which a HEF scheme would be introduced may be a momentous task.

It is important to note that this variant of demand-side financing that would fall under the 3rd-party purchaser category, also appears to have required, for its success, two significant inputs. The first was the involvement of international bodies MSF and UNICEF who assisted with establishment and set-up of the scheme. The second was significant improvements to the supply-side environment, negotiated between these bodies and the Cambodian Ministry of Health, in which a 'New Deal' for health workers was put in place to address the causes of poor service provision, and which 'immediately resulted in better staff motivation and higher user rates' (2004:23). The 'simple' introduction of a demand-side initiative in the form of a health equity scheme in the absence of concerted reform to supply side services would therefore have delivered questionable results.

In its establishment of a new government-facilitated health insurance scheme aimed at enabling the poorest sectors of the population to pay for health care, China is employing the innovative step of separating the task of purchase of services from

¹⁶ The characteristics used to distinguish between these two categories were: 'Extremely poor = small (thatch house, <0.5 ha land, no cows, food shortage more than 5 months, no savings, live on day-to-day basis, can only borrow small amounts' and 'Poor = wooden house, >1.5 ha land, 2 cows or less, bicycle, food shortage less than 4 months, small savings <US\$5, borrow regularly' (2004:25). The absence of correlation with the DRCCP indicators of vulnerable groups will be noted here.

¹⁷ Identification was based on patients' lack of basic items such as food, utensils, mosquito nets and clothing (2004:24).

that of providing them, with the purchasing ministry, here, that of Civil Affairs, expected to exert more exacting standards in monitoring the quality of provision, than would the Ministry of Health in monitoring its own services (Bloom, 2004:5). Analysis on the impact of this division of labour on the quality of care however, is yet to be published.

How effective are cash transfers in facilitating greater service use by the poor?

The PROGRESA project in Mexico was found to have 'significant positive impact on public health care utilisation, nutrition monitoring, health status of adults and children (measured by self-reported illness rates)...' (IFPRI report cited in Ensor, 2003:40)¹⁸

Vouchers have had some success in increasing the uptake of certain services among targeted groups. 'International evidence suggests that vouchers have been successful in raising the consumption of key services amongst certain groups. Evidence also suggests that vouchers can be used to target vulnerable groups' (Ensor 2003:4). Such schemes are judged to be most applicable for providing health services to the poorest in areas where a) demand is predictable and b) the targeted group is relatively easily identifiable (Ensor, 2003:4). This implies they are inappropriate for assisting the poorest to access curative services, which are not predictable and where demand for inappropriate treatment may need to be controlled, but could be effective in MCH services (Gooding and Standing, 2004:14).

The evidence is less positive on the effect of vouchers on improving service quality through increased competition (Ensor, 4). Serious concern has been expressed about the quality of the education provided to students benefiting from the education stipend programme in Bangladesh. For example, the Bangladesh Food For Education project managed a spectacular increase in female enrolment in secondary schools, but saw quality of education fall largely due to this success (Islam, 2003:6), confirming supply-side interventions were also required.

This is especially the case where demand-side initiatives are introduced in a monopoly-provider situation, where service-quality in many LDCs is widely perceived to be low. Thus, significant supply-side inputs are likely to be required also to improve the quality of care and thus demand for service (Ensor, 13). Significant investment was made in supply of services prior to the introduction of The Cambodian Health Equity Fund (Hardeman et al, 2004).

Evidence also suggests that DSF initiatives must take a comprehensive approach to barriers to health-seeking behaviour among the poorest, including offsetting indirect costs such as transport, income-loss and medication which often exceed the direct costs encountered by the poor considering seeking treatment (Ensor, 29). We do not know very much about the threshold at which the very poor will find it worth their while to encash their transfers in health DSF programmes.

DSF mechanisms are not a cure for existing institutional weaknesses. They may encourage certain 'perverse' behaviours by providers and administrators. These include collusion between providers to create cartels/ exclude certain categories of clients, development of a 'market' in vouchers or other transfers, and over medicalisation where alternative treatments may be more appropriate (Gooding and Standing 2003: 11). This is particularly a risk in LDCs with weak institutions.

• ¹⁸ However, no details given on the scale of this initiative and the report (the most comprehensive review of demand-side financing in health and education to date?) contains no reference to attempts to scale up cash transfer programmes within health.

A recent study of delivery mechanisms of cash transfer programmes in Bangladesh found that on the whole, the schemes work reasonably well, given their size and the kinds of institutional constraints faced by poor countries.

The findings indicate that the schemes are over administered but under governed. That is to say there are too many structures and personnel involved, particularly in the IGVD scheme, but insufficient checks and balances on rent seeking, inappropriate choice of beneficiaries and leakage. For instance, there is not enough hands on monitoring of for instance the distribution at delivery, giving too much licence to abuse by local officials such as the weighman for grain which is given out, and no separate appeals processes for aggrieved beneficiaries. This could be remedied by some carefully targeted changes to the way the schemes are managed. This could include addressing the perceived transaction costs particularly in the non-cash transfers which create a view among agents administering the programme that it is legitimate to reduce the amount of the transfer to the beneficiaries .

Thus , the development of appropriate administrative and governance institutions is therefore absolutely critical to DSF success. These will vary with the mechanisms adopted, but include:

- Capable monitoring and governance bodies at both national and local level
- Community bodies able to play an informed and empowered advocacy / watch-dog role (*ibid*)
- Processes to liaise with communities, engage and win support of the community for the initiative, and set the price of the transfer correctly (Gooding and Standing, 12)
- Development of competent third-party purchasing organisations where beneficiaries are at informational disadvantages in evaluating which service they require / where best to access it (Ensor, 13-14)
- Quality-assurance / standards agencies that can determine / certify providers able to supply services to certain standards (Ensor, 13)

Summary

Different forms of DSF clearly have potential for reaching the poorest through a combination of targeting specific groups and individuals and providing positive incentives to take up services. However, in the health sector, relatively few interventions have been systematically tried and evaluated in low income countries. We need a better body of evidence to make an informed judgement. Evidence so far suggests that they are better at increasing coverage than ensuring quality unless there are parallel interventions on the supply side aimed at raising quality standards.

7. What gaps are there in knowledge and evidence of scaling up initiatives?

The gaps are considerable. There is a serious lack of empirically detailed accounts of the institutional arrangements and delivery mechanisms in both small-scale and expanded programmes. Without this more detailed information, it is difficult to go beyond fairly general principles such as the need to manage leakage and keep rent seeking within acceptable bounds. We need more information on the substantive ways in which these problems are managed.

We also know little about the beneficiary perspective. How do the very poor view these programmes? What factors lead them to participate or to exit? Where are there positive examples of consultation and involvement? To what extent is it possible to create or sustain voice in expanded programmes?

Very little was found on the economics of scaling up. There do not appear to be any cost-benefit studies on scaling up. For instance, what is the trade off between costs of best or good practice on institutional frameworks, targeting and monitoring and regulation of programmes set against benefits/outcomes for the very poor?

What are the institutional obstacles to scaling-up successful small-scale interventions?

Costs may be prohibitive or unsustainable:

- Likening certain successful small-scale programmes to retail 'boutiques, too costly for the masses' the WB summary on scaling-up community driven development points to examples of programmes with large budgets per capita that donors are prepared to finance on a small-scale, but that are impractical at scale (Binswanger et al 2003: 5).
- Even where unit costs are affordable, national scaling up can fail to mobilise the required co-financing from communities or local governments (Binswanger et al, 2003:5)

Co-production between local constituencies and local governments/agencies is harder to replicate on a regional / national scale:

- While these arrangements may work in particular local contexts, due to the quality of relationships between parties, commitment of key personnel etc, on a larger scale it is harder to ensure that the well-documented institutional problems which can affect co-production (incompatibility of incentives of co-producers, differences in values and experiences of co-producers, lack of clarity of rules and responsibilities) do not render the initiative unworkable. (Binswanger et al, 2003: 5-6). Loewenson's review of 100+ cases of attempted state-civil society participation in health, found that many of these were typified by an 'absence of clear mechanisms' to 'enable such relationships between the state and CSOs' (2003:9)

Problems with scaling up targeting mechanisms

- Scaled-up programmes aiming to target the very poor face significant data challenges. To target the poorest most effectively, sophisticated demographic information is ideally required. This is highly unlikely to exist in a Least Developed Country (LDC) context (Gibbons: 2004, 14-15; Barrett and Clay, 2001:2). Therefore, small-scale programmes in LDCs reaching the poorest often rely instead on sources of local knowledge (CBOs, NGOs, community representatives) to assist targeting, and such sources, being particular to their localities, are not highly amenable to being scaled-up.

Risks of elite capture of decentralised resource flows

- This may be an issue where allocation to localities is decided centrally, but dispersal to beneficiaries is determined at local level in order to exploit the information advantages of using some kind of local authority (Ravallion, 2003). Recent work by Das Gupta et al (2003, cited in Gillespie, 17), as well that by Galasso and Ravallion (cited in Ravallion 2003: 22) exploring Food-For-Education community targeting in Bangladesh, finds that where there is more intra-community inequality of wealth, elite capture of benefits is more likely. There is a danger in clientelistic societies that while resources may reach the poorest, clients of the elites dispensing resources may benefit disproportionately and exclude certain sections of the poorest – as was BRAC's experience in the IGVD programme (Matin, 2001:15– 19)

Are certain principles for scale-up discernible?

The 'gradualist' principle of scale-up is a point emphasised by several analysts.

- In analysis of five separate instances of scaled-up pro-poor programmes, Gillespie asserts that 'scaling up should always start with one province or district to prove that the scaling-up can indeed be successful' (Gillespie, 2003, 16). The medium to long-term nature of the need to develop capacity is perhaps the most pivotal reason for adopting a gradualist approach.
- This echoes Islam's analysis of factors behind the success of the Bangladeshi female students scholarship program, one of which he asserts, was the staged approach taken in expanding the programme: 'the large scale of the operation and ultimately universal coverage was done in stages; not at a time. This has also enabled the sector to develop management capacity in phases to undertake such a huge operation' (Islam, 2003:7 and Standing and Gooding, 2003:12)

Perhaps paradoxically, scaling up requires a serious commitment to shifting power to the local level:

- Small scale 'islands of excellence' are often facilitated by mobilisation of community actors (CBOs, NGOs) with the local knowledge and capacity to reach the poor. 'Global experience [of scaling-up]...shows strong political commitment to decentralisation and empowerment is essential, and a local champion often leads the process' (Binswanger et al, 2003: 17); 'the decentralisation of authority and resources –are key' (Gillespie, 2003:16).
- Applying the principle of subsidiarity also cuts economic costs and improves transfer efficiency (Binswanger et al, 2003: 22)
- An illustration of recognition of the need for more powerful local structures in large-scale programmes targeted at the poorest is provided by China's forthcoming programme of getting health insurance to the most marginalised which acknowledges the need to strengthen elected structures if they are to monitor service provision (Bloom, 2004: 7)

Enabling institutional environments are best created within existing structures however imperfect: (Gillespie, 2003: 19 & 35)

- Parallel structures risk undermining and alienating existing infrastructure, however imperfect (Summers in *ibid*: 19). 'Work with, don't bypass government' (Gillespie, Power Point Presentation, slide 14).

If rapid scale-up is sought, ease of replication is key:

- The simpler the institutional framework and the less complex the relationships between actors, the swifter and more successful the initiative is likely to be (Binswanger et al, 2003: 18). This bodes ill for complex co-producing arrangements.
- Success is conditioned by local cultural and social systems so 'the best practice here may be the absence of a best practice' (Mansuri and Rao in Gillespie, 35).

What supporting role could agencies like DFID play in developing institutional capacity for scale-up?

- Civil Society Organisation capacity to identify groups within the lowest socio-economic categories is often seen to surpass that of the public sector. This was seen to be the case in the Cambodian HEF, and is noted by Loewenson as a frequent advantage of CSO involvement in pro-poor health interventions (2003:6), as well as by Simnowitz in a comparative assessment of Grameen's pro-poor

targeting capacities. Support to disseminate and train other appropriate bodies in targeting methodologies developed by community organisations could usefully be provided by international agencies, most especially as accurate identification of the poor appears to be a primary obstacle in getting health services to them.

- Support to assist governments or NGOs in developing the necessary skills for setting up alternative financing schemes such as DSF. This includes setting up agencies to contract services, compute voucher values, allocate and exchange vouchers for payment, and monitor schemes (Ensor, 31)
- Support for the development of accreditation bodies or processes for quality assuring governmental / private service providers participating in demand-side and other interventions to meet the health needs of the poorest.
- Support for effective consultation processes, information and awareness raising campaigns to reach the poorest where schemes are being designed / implemented for these groups.

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