Allocating resources for serving the poor: a core factor in development

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Background

The poorer people are, the less likely they are to reach formal government services. The poorer people are, the higher the proportion of their limited private disposable income they spend on health care.[1] As Montagu and Graff comment in their important and timely paper in this issue of the Journal, "the challenges for the delivery of SRH services in developing countries that are both sustainable and equitable are not easily overcome".[2]

All efforts towards achieving the Millennium Development Goals, safe motherhood initiatives, international agencies and concerned non-governmental organisations (NGOs) are avoiding the core issues if they do not find more effective ways to finance family planning, safe deliveries, and treatment of sexually transmitted infections (STIs), especially for the world's poor. Faced with limited resources there is no room for expensive, small-scale initiatives: if the projects are not cost effective, they cannot be replicated broadly within realistic budgets.

Foreign aid

William Easterly, in his book *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done Much Ill and So Little Good*, points out that the more foreign aid African countries have received, the slower has been the growth in *per capita* income.[3] Perhaps Easterly is overly harsh, but the record of foreign aid is certainly uneven and in places deeply disappointing. There is something mildly amiss when after $2.3 trillion in foreign aid over half a century, the absolute number of maternal deaths in Africa in the first decade of the 21st century is likely to be greater than in any other 10 years in the whole history of the continent.

It has been especially difficult to translate foreign aid support, such as from the Department for International Development in the UK, into programmes that reach those in the greatest need. Montagu and Graff point out that financing decisions about sexual and reproductive health (SRH) are often based on "political considerations". In particular, sector-wide approaches are unsuitable for supporting family planning. In weak states, corruption may bleed away money given to governments at several levels. International NGOs often burn up funds with regional and country offices and, again, little money trickles down to those in greatest need. The 2007 report of the All Party Parliamentary Group on Population, Development and Reproductive Health highlighted that "it is important that funding for family planning be *specifically allocated and effectively tracked*".[4]

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Private vs public financing

On the whole, support for international family planning has been more successful than many other areas of international assistance. In countries where the unmet need for family planning has been matched by giving women correct information about, and easy access to, contraceptive methods, the poorer women as well as richer have been able to make decisions about their childbearing, and family size has fallen, often rapidly. As Cleland *et al*. wrote in 2006: "The promotion and availability of family planning in resource-poor settings represents one of the most significant public health success stories of the past century".[5]

Unfortunately, following the 1994 International Conference of Population and Development, donor budgets for family planning collapsed and the administrative commitment evaporated.[6] Largely as a result of this loss in funding, the unmet need for family planning has increased and inequities in family size have grown.[7] Can innovative methods of funding help repair this loss of finance and leadership, in order to bring access to reproductive health services to the poorest?

Many modern methods of contraception, such as oral contraceptives, copper intrauterine devices (IUDs) and injectables, are now available at low cost, although they can still be too expensive for the poorest billion. Harvey, who helped conceptualise family planning social marketing programmes in the developing world, finds that contraceptive prevalence remains extremely low if the cost of methods exceeds 1% of *per capita* disposable income.[8] When this empirical rule is applied to Africa, then over 90% of individuals cannot afford the full cost of modern contraception. For the slightly richer clients who can afford modern contraception, extremely low prices, paradoxically, can be a disadvantage because contraceptives may not generate enough profit to encourage the private sector to provide them. Finally, low-income people find it difficult to pay for pregnancy prevention when food, shelter, and curative healthcare are more immediate needs.

Montagu and Graff observe that "public financing for SRH services in this example has limited benefits for the poor because it is directed primarily at services that are delivered by providers in urban settings serving higher income clientele".[2] We recognise this limitation and it is a critical one when a very large percentage of a country's population is in rural areas. We also recognise, though, that reaching the poorest economic quintiles with any kind of health services through the private sector providers has its limitations. In Indonesia, when the government focus on family planning was reduced in the 1990s, the private sector was able to take up a good part of the slack. But in Africa, by contrast, people are an order of magnitude poorer than in Indonesia. When African countries lost much of their funding for family planning in the 1990s, the private sector providers were unable to sustain the fall in family size, which had begun in the 1980s. The poor were simply unable to pay for the contraceptive services and information they needed. This setback has given rise to growing disparities in total fertility rates (TFR) between the lowest and highest economic quintiles. In Tanzania, Mozambique and

Kenya, the richest economic quintiles saw a fall in TFR while the poorest quintile TFR rose.[9] In Kenya, the richest economic quintile now average three children per woman, while the poorest women average nearly eight. In Kenya's lowest quintile, 32.7% of women report an unmet need for family planning, nearly twice that of the richest quintile.[10] These differences in family size translate into painful inequities in education for children and the health of mothers and their families, as well as fewer employment opportunities for young adults. To make sure that the poor specifically have access to family planning methods and information, it is important that governments make a priority by allocating a permanent line in their budgets to family planning initiatives.

Output-based assistance

In countries with some degree of wealth and relatively mature bureaucratic structures, conditional cash transfers, as described by Montagu and Graff, are showing considerable promise. But for the ultra-poor, especially in sub-Saharan Africa, alternative funding strategies are needed. One prospect for this funding is output-based assistance (OBA) or 'smart aid', in which women are offered coupons or vouchers for a low price they can afford.[11] Montagu and Graff refer to the success of the voucher systems in Taiwan and South Korea,[3] and this opportunity is so important for reaching the poor today that we would like to expand on it. The Kenyan OBA Safe Motherhood programme today, run by an international accounting firm, is an excellent example. In this programme women can take their vouchers to a government hospital, a faith-based hospital, or an accredited private physician or midwife who cashes in the coupon to receive from the accounting firm their negotiated fee when they provide antenatal care and delivery. Rather than top-down supervision – which often doesn't work in a low resource setting – OBA of this type works from the bottom up by giving the client a choice of providers. As clinics and services must compete for customers, their quality tends to improve. Additionally OBA allows a donor to target particular services, such as a safe delivery, or to target a special population, such as young people exposed to STIs. A recent evaluation supported by the German Credit Bank (KfW, Kreditanstalt fur Wiederaufbau), Uganda OBA programme demonstrated a significant impact on the treatment and reduction of STIs.[12] It is also worth noting that what is now among the world's largest family planning programmes, FamilyPACT in California is really an OBA project, in that it depends on an item of service payment. This service provides contraceptives to more than 1 million women and men and by preventing pregnancies, saves about 2.2 billion dollars, or $5.33 for every dollar spent, in what would have been costs of care and treatment of pregnant women and children up to 5 years of age.[13]

OBA is not a panacea but it needs to be more widely used to finance all types of health care. For example, OBA would be an ideal way to handle the tragedy of obstetric fistulae. Those who do struggle to provide health care for the poor in Africa and elsewhere are painfully familiar with fistulae. Surgeons in Africa know how to repair them – they lack just one thing: money. An item of service payment for every fistula repaired is the only thing needed to treat this terrible affliction in a low-resource setting. Access to family planning could also benefit a great deal from an OBA approach. Although some may be critical of targeted family planning programmes, it is important to start with a few strategic SRH interventions when limited budgets cannot effectively support all services on a large scale. Montagu and Graff point out that the successful Pro-Familia programme in Columbia was "initially limited to family planning, but in parts of Columbia the contract to Pro-Familia has expanded to include a wide range of services".[2]

Concluding remarks

In the context of this financial crisis, and with further expected drops in donor funding, we need to find alternative paths for financing. In fact it might be more useful to create a self-sustainable funding scheme. We underestimate the amount of money that the poor are willing to pay for their health. *The Next 4 Billion* shows that the poorest people around the world spend $158.4 billion dollars on health care commodities in the formal sector alone.[14] However, it also shows that they spend most of their money on treatment rather than preventive services. Our vision is that OBA may have the potential to create a demand for prevention that is accessible and affordable among the poor. Furthermore, OBA has the potential to put power into the hands of the poor to select for themselves good-quality services and respectful providers.

Statements on funding and competing interests

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References

1 Prata N, Montagu D, Jefferys E. Private sector, human resources and health franchising in Africa. *Bull World Health Organ* 2005; **83**: 274–279.
2 Montagu D, Graff M. Equity and financing for sexual and reproductive health service delivery: current innovations. *J Fam Plann Reprod Health Care* 2009; **35**: 145–149.
3 Easterly W. *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good.* Oxford, UK: Oxford University Press, 2007.
4 All Party Parliamentary Group on Population, Development and Reproductive Health. *Return of the Population Growth Factor: Its Impact Upon the Millennium Development Goals.* 2007. http://www.appg-popdevrh.org.uk [Accessed 22 May 2009].
5 Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *Lancet* 2006; **368**: 1810–1827.
6 Campbell M. Why the silence on population? *Popul Environ* 2007; **28**(4–5): 237–246.
7 Campbell M, Cleland J, Ezeh A, Prata N. Return of the population growth factor. *Science* 2007; **315**: 1501-1502.
8 Harvey PD. *Let Every Child Be Wanted: How Social Marketing is Revolutionizing Contraceptive Use Around the World.* Westport, CT: Greenwood, 1999.
9 African Population and Health Research Center Additional Evidence in All Party Parliamentary Group on Population, Development and Reproductive Health. *Return of the Population Growth Factor: Its Impact Upon the Millennium Development Goals.* 2007. http://www.appg-popdevrh.org.uk/ [Accessed 22 May 2009].
10 MEASURE DHS, ICF Macro. Final Report of Kenya: Standard Demographic Health Survey. Fertility and Family Planning (Chapters 4 and 5). 2003. http://www.measuredhs.com/pubs/pub_details.cfm?ID=462 [Accessed 22 May 2009].
11 Janisch CP, Potts M. Smart aid – the role of output-based assistance. *Lancet* 2005; **366**: 1343–1344.
12 Bellows B. Evaluating a voucher program for treatment of sexually transmitted infections (STIs) in Uganda. A presentation given at Vouchers for Health: Increasing Access, Equity, and Quality, Gurgaon, India, 12–13 April 2007. http://www.psp-one.com/section/technicalareas/health_finance/vouterworkshop2/voucherworkshop [Accessed 22 May 2009].
13 Amaral G, Foster DG. *Family PACT Program Evaluation: Cost Benefit Analysis for Calendar Year (CY) 2002.* Berkeley, CA: Center for Reproductive Health Research and Policy, January 2005.
14 Hammond A, Kramer WJ, Tran J, Katz R, Walker C. *The Next 4 Billion: Market Size and Business Strategy at the Base of the Pyramid.* The health market (Chapter 2). World Resources Institute. March 2007. http://www.wri.org/publication/the-next-4-billion [Accessed 22 May 2009].