
MSI's health financing assessments 2012-2015: What did we learn about UHC financing and contraception? Four 'Ps' matter

An external findings and discussion paper
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Introduction

Universal health coverage, *the single most powerful concept that public health has to offer*,¹ challenges countries to provide quality, essential health services to all people in need without causing them financial hardship². Achieving UHC demands quality health services and geographic health service coverage but also requires health financing reforms³, the focus of this paper. Since 2012, Marie Stopes International (MSI) has assessed health financing approaches to contraception in 20 countries in Asia and Africa for sustainability and equity objectives. We present here a retrospective of the trends we identified in how health financing systems typically handle these services. **Our findings highlight that it will be insufficient for our sector to ask for contraception to merely 'be included' in UHC - the details of inclusion matter.** We conclude by proposing how contraception would best be addressed under UHC health financing reforms in terms of 'four Ps': the people covered, the package extended, the providers contracted, and the payment approaches used.

MSI's health financing assessments

MSI's health financing team, established in 2012, facilitated 20 health financing assessments (HFAs) in sub-Saharan Africa and Asia over the period 2012-2015. The principle motivation for the HFAs has been to build sustainable, equitable delivery channels for contraception based on understanding of who pays (or will pay) for these services on behalf of our clients. Given MSI's focus, we scrutinized purchasing and risk pooling mechanisms more than approaches to revenue generation, though all three constitute the bedrock of health financing systems.⁴

The HFA relies on policy review followed by national stakeholder interviews to assess the state of implementation.⁵ HFAs then aim to answer four basic questions:

1. **People.** What is the overlap between the existing health financing streams and target client profiles (i.e. low income)?
2. **Package.** Do these health financing streams include a choice of contraception services?
3. **Providers.** Are these health financing streams available to the non-state sector, including small scale outlets, not-for-profit providers, or specialist health providers like MSI?
4. **Payment.** Are the payments for these services direct, reimbursed for specific outputs, adequate, and reasonably timely?

The HFA analysis concludes with a country team debriefing to identify and plan response to opportunities and barriers seen in the national financing context.

¹ Chan, M. 'Address to the 65th World Health Assembly', speech presented at World Health Organization, Geneva. 2012

² World Health Report 2010.

³ Kutzin, J. 'Anything goes on the path to universal health coverage? No.' World Health Organization, 20 avenue Appia, 1211 Geneva 27, Switzerland. 2012. *Bulletin of the World Health Organization* 2012;90:867-868

⁴ World Bank. Health Financing Revisited: A Practitioner's Guide. Eds Gottret & Schieber. 2006.

⁵ MSI's health financing assessment tool and methodology has been developed with the joint support of USAID, DFID, NORAD and DANIDA and is available to the sector – please request through correspondence with the authors.

In 2015, MSI's health financing team conducted a retrospective of the twenty HFAs. See Figure 1 for country assessments in the review. The retrospective served to improve the HFA process and outcomes for MSI as an organization, including solidifying our programmatic response to different market contexts; these outcomes have been separately documented^{6 7}. Some of the trends identified in the national health financing environments were relevant beyond MSI and these are shared here for the purposes of discussion at a time when our wider sector has noted knowledge gaps⁸. Specific country findings are not presented in this paper.

Figure 1: Countries included in the review of 20 MSI health financing assessments



Findings overview

General health financing assessment findings

Overall, MSI's HFA retrospective saw that *private* financing for contraception typically consisted of out-of-pocket payments in the countries surveyed. In general, private insurance benefits were shaped by sickness cover and value-added services, while employment cover was shaped by legal requirements for employers to provide access to health care (often without reproductive health services specified) for its workers. As a result, we found few instances of private insurance or employment health cover that explicitly included contraception; namely, four small scale schemes in the 20 countries assessed, with two additional schemes that catered to contraception simply because any health care related costs were permissible with appropriate receipts. No countries we assessed had community-based health insurance that covered more than a few hundred members *and* included contraception.

The greatest share of HFA findings therefore relates to what we found in *public* financing arrangements for contraception. With or without donor support, all governments either fully or partially subsidized contraception at the point of use. Various approaches were practiced, many of which had substantial downfalls. MSI notes five trends as follows.

⁶ Appleford, Gabrielle. Health Markets Review. Jan 2015

⁷ Appleford, Gabrielle, Mazzilli, Caitlin et al. MSI's approach to markets. Forthcoming 2016.

⁸ WHO/UNFPA Dec 2015. Systematic reviews of financing mechanisms for family planning: evidence and knowledge gaps. Meeting report. Harvard T. H. Chan School of Public Health, Boston, USA

Five trends in public health financing for contraception

1. Contraception financing is often input-based

A typical way for governments to finance contraception is through input-based financing. This means simply paying health worker salaries and providing state-procured or donated commodities. In return, providers are expected to deliver contraception to clients free of charge or at highly subsidized rates. In 12 of 20 countries surveyed - and particularly in sub-Saharan Africa - contraception services were made free of charge in the public sector using this approach alone, and three had included the private faith-based sector by applying the same arrangements (i.e. salary and commodities in return for free services at the point of delivery).

While making contraception free at the point of use is laudable and aligned with the financial protection objectives of UHC, our HFAs have noted input-based financing for contraception to be troubled in practice. Much has been written about the low-powered incentives of input-based financing for health service provision in general^{9 10 11}, but we have observed particular impacts on contraceptive method choice linked to this financing model. Simply put, providers tend to shirk contraception as a service when there is limited benefit in spending more time and effort serving any given client. This can contribute to a failure to offer a full range of contraceptive methods and of clinical methods (long-acting, reversible or permanent) in particular. Instead, **contraception gravitates towards the ease of dispensing contraceptive products under input-based financing.**

An example can illustrate this effect. One HFA interviewed managers of faith-based facilities which benefited from Ministry of Health-paid salary time and donated commodities to provide free contraception. Each described a work pattern of solely delivering injectable contraceptives until supplies stocked out, a story which was backed up by their FP registers. One manager said, ‘family planning is not interesting financially.’ **There was no loss to the facility when contraception could not be provided.** By contrast, deliveries reimbursed through government service-level agreements were seen to directly affect facility cash flow and income. In this context, delivering more labour and resource intensive contraceptive services like implants, IUDs or permanent methods, even if trained and equipped, would depend on the personal motivation of staff.

Governments that rely on input-based financing might add performance-based pay to align provider incentives with key outputs. In the country described above, a performance-based financing pilot operated in two regions and included one of ten indicators as the ‘total number of family planning users (any method) increased’ in the monitoring period. While we understand the need to resist ever more indicators, we also acknowledge that this one indicator is so easy to reach with repeat short-term method supply that it will not address motivation for a full and more effective contraceptive offer. In any case, the countries we surveyed did not have performance-based financing schemes operating at scale.

A further issue is that **there is limited scope for input-based financing to be used as a tool to engage the private sector in contraception provision.** This excludes a significant proportion of health system capacity, including many of the most trusted providers, and so reduces access. While some countries do allow the private sector access to publicly procured commodities, the salary and overheads that contribute to service provision are not covered and out-of-pocket charges remain for clients. In such cases, our HFA interviews revealed tensions between government and the private sector around the necessity of these additional charges.

⁹ In economics, low-powered incentives would be associated with little or no personal financial gain while high-powered incentives would lead to direct personal profit

¹⁰ Willis-Shattuck, Mischa et al. “Motivation and Retention of Health Workers in Developing Countries: A Systematic Review.” *BMC Health Services Research* 8 (2008): 247. *PMC*. Web. 6 June 2016.;

¹¹ Henderson LN, Tulloch J. Incentives for retaining and motivating health workers in Pacific and Asian countries. *Hum Resour Health* 2008; 6: 18.

Overall, we see that input-based financing for contraception undervalues the service and overemphasises the commodity in a way that weakens supply and limits client choice.

2. Where contraception is a reimbursable service, a dedicated family planning or population fund is often in place

By marked contrast, a sub-set of countries assessed in South and Pacific Asia (five) did have dedicated financing streams to reimburse contraception services. Three of the five had a focus on male and female sterilisations, and the basic incentives are high-powered¹² to an extent that **genuine contraceptive choice is disputed in practice**. The remaining two countries also had named 'population' financing in place but without the lopsided focus on sterilisation.

Beyond the problematic ethical considerations of some of these population funds, self-standing contraception financing is generally questionable in the UHC era. Integration of contraception financing into the health financing system was a theme of policy discussion with varying significance in the five contexts. In the future, we may expect the gradual transfer of contraception financing to wider system approaches.

But the transfer of contraception financing to wider systems approaches needs to be carefully watched. In a middle-income country we assessed, the national health insurance (NHI) scheme was developed without an integration plan for the population fund, which operated in parallel. Meanwhile, government allocation to the fund has been reduced year on year, just as the NHI has been the growing focus of national health system financing. This has meant a net reduction of public financing for contraception in the country. Transferring population funds on the one hand may allow the opportunity for revisiting and better aligning incentives with contraceptive choice, but it may also risk burying contraception in wider benefits packages or forgetting it all together.

3. Where maternity financing initiatives have been introduced, contraception has not always followed

In another regionally specific trend of a very different nature, our HFAs in West Africa (five) found that contraception frequently remained a fee-payable service in private and public facilities despite growing exemption schemes for safe delivery and care for children under-five. In several instances, this has led to the unbalanced situation whereby women who do not want to be pregnant are the ones who must pay for services, and pregnant and lactating women are exempt. In a region with some of the lowest contraceptive prevalence rates in the world, the logic of such health financing approaches is dubious. In the example of Ghana, the period of the National Health Insurance Scheme (NHIS) expansion has coincided with a strong rise in institutional deliveries while increases in contraceptive prevalence (excluded from NHIS) have not followed.¹³ **The linkages between contraception and maternal and child health have apparently not convinced public financing decision makers in this region.** Nor, perhaps, have the direct health system cost savings that appropriate financing of contraception can make.¹⁴

4. Contraception is weakly defined in primary health care packages or under capitation

The era of UHC has elevated national or social health insurance (NHI) as a health financing instrument. In ten of the twenty countries assessed, NHI was in various stages of development.

¹² In economics, low-powered incentives would be associated with little or no personal financial gain while high-powered incentives would lead to direct personal profit

¹³ World Health Organization. (2013). Accelerating Universal Access to Sexual and Reproductive Health: Agenda for the African Region of the World Health Organization. Brazzaville: WHO Regional Office for Africa.

¹⁴ Guttmacher Institute, Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012. (2012)

Domestic debates will pull and shape any NHI, but governments must ultimately decide what services go in the insurance package as reimbursables (paid retrospectively on services delivered) and what services can be financed through other means, largely pre-paid. Strategies in the latter category might include making a package of primary health care services free in the public sector using input-based financing (as described previously) or by developing a package that is paid through capitation¹⁵ and which allows the option of leveraging both public and private sectors. It is generally the *combination* of insurance reimbursable services *and* the chosen prepaid primary health care financing approach that create the UHC financing platform.

On which side of the divide does contraception tend to sit? **We found that seven of ten of the NHI schemes in the countries surveyed had opted to keep contraception out of the reimbursable package.** Just one of these had a provision for reimbursing long-acting reversible and permanent methods, and another two for only permanent methods (when claimed as day surgeries) – but in all three cases the volume of the contraception services being claimed was highly constrained (either providers didn't know they could claim for these services or else payments were not flowing at the time of the HFAs).

One NHI scheme had expressly included contraception services (defined as 'family planning' without reference to methods) under the capitation package. Another NHI has yet to implement contraception in the benefits package but seems to be leaning towards capitation for these services as well.

While these instances hardly constitute a trend, we predict that the sensible global push for cost-containment strategies, coupled with the well-intentioned view that contraception is primary health care, may increasingly land contraception in capitation financing to which it is decidedly ill-suited. Not only does contraception absorb providers' capitation, but the larger costs that it might prevent down the line – such as obstetrics – rarely do (they are typically reimbursed) meaning there is limited financial ramification of *not* providing contraception. Using capitation to pay for contraception was briefly tested in Indonesia's national health insurance, JKN, before ultimately opting for case-based payments for long-acting reversible and permanent methods:

"Providers of services are given a sum of resources (capitation). Thus, a large number of JKN members who are healthy and do not need to utilize health services will be profitable to the providers. This is very different from Family Planning, the focus of which is on recruitment of increasing numbers of acceptors from the ranks of those facing unmet need for contraception. These acceptors have to utilize FP services from FP providers. **If the same system of capitation is used as the JKN for health, the higher the utilization of FP services, the less profit the providers will receive.** This is a crucial threat to Indonesia's efforts to increase CPR, reduce unmet need and therefore reduce TFR. (There is already evidence that some Puskesmas are reluctant to provide FP services which absorb their capitation)." [our emphasis]

Meanwhile, NHI in development in another seven countries surveyed had no explicit plans to reshape how contraception was financed due to its early exclusion from the insurance package. And why? The simple answer may be because contraception is being financed by other means, but the longer answer needs scrutiny of the political economy of these decisions.

Taken together, **much of the attention to UHC health financing reforms is currently drawn to schemes that risk having little impact on contraception, and it will remain weakly formulated in input-based financing or capitation of primary health care packages.** If we are not careful, this will mean no change to the status quo.

¹⁵ Capitation systems award a provider a set amount 'per head' for each enrolled person at the facility, per period of time, whether or not that person seeks care. Capitation works to ensure providers are sparing with their resources and do not 'over service' enrolled members, and is thereby considered an important cost containment strategy in many health systems

But a further and final problem with the disproportionate attention to NHI is that population coverage is currently slow to reach those for whom unmet need for contraception is highest. Much has been written elsewhere about this lag in coverage to the poor¹⁶. Our sector is only starting to discuss coverage of adolescents¹⁷, but it is also greatly problematic. Even with well informed NHI package decisions about contraception in place, relevant population coverage would pose the barrier.

5. Public financing schemes are often biased against midlevel private facilities

Our HFAs showed that smaller facilities operated by low-to-midlevel providers were the least able to capture public financing opportunities that were emerging or operating in the countries we assessed. The most frequent facility *type* to access public financing - for contraception or otherwise – was any public facility, followed by faith-based facilities, then large private inpatient hospitals or polyclinics, then full private primary health care units. In the experience of the HFAs, last on the list were clinics that did not offer the benefit of contracting or empanellment for full primary health care services, such as nurse/midwife-run maternity homes and day clinics. Meeting the requirements for contracting and insurance accreditation often means having many rooms, services and staffing structures beyond the reach of small facilities. Their exclusion presents a missed opportunity for reaching women as these facilities are in many instances within the geographic reach of poorer groups. The service offer of maternity homes is particularly well-suited to contraception and their clients (and this is why these providers are MSI's target for social franchising). The inclusion of trusted community-located providers will be critical factor in expanding access to underserved populations. Their role is well articulated by the World Bank and others¹⁸. However, we heard reservations from NHI agencies in several countries about having an excess number of provider contracts to manage. We see the need to resolve this conundrum if the UHC agenda is to make significant impact on contraception and on affordable access to services at the community level.

Recommendations. What will successful financing for contraception look like under UHC?

Having reviewed health financing approaches to contraception in twenty countries around the world, MSI argues that it will not be enough to advocate for contraception to be 'included' under UHC. For real contraceptive choice to be available for those most in need, the total amount of public financing matters, but so does alignment of critical pieces in financing schemes (Figure 2). Getting the pieces right means bringing together:

1. **People.** Coverage needs to be designed for including the poor, underserved, marginalized and vulnerable today, or else it will fail to be the vehicle to reducing unmet need that our sector has committed to by 2020. It's that simple.
2. **Package.** Contraceptive choice needs to be included within the defined UHC benefits package, with careful articulation of methods and how they will be handled under primary health care (and accompanying payments). Contraception must accompany all maternal health packages.
3. **Providers.** UHC schemes need to purchase quality services on behalf of the population in appropriate locations and at appropriate, cost-effective levels of the health system. Expansion of provider purchasing is critical. This should extend to midlevel provider operated clinics whose services are accessible to much of the population, and where contraception fits well into the service offer.

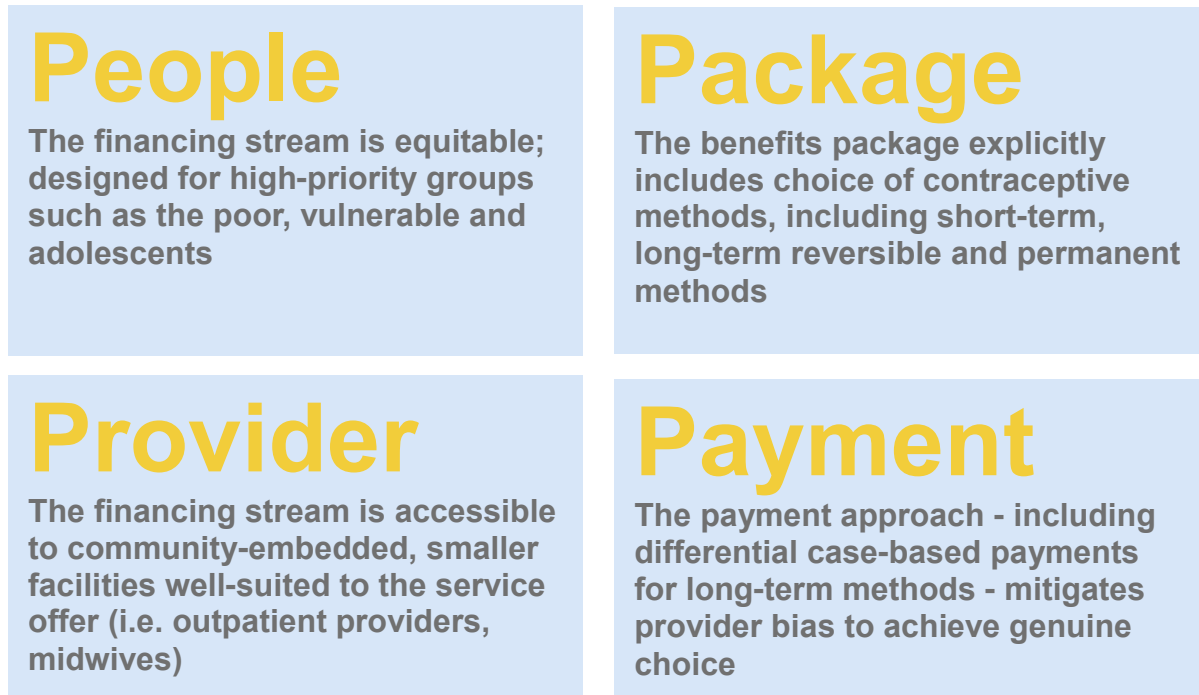
¹⁶ Oxfam Report, 2013. Universal Health Coverage: Why health insurance schemes are leaving the poor behind. 176 Oxfam Briefing Paper

¹⁷ Catriona Waddington & Claudia Sambo. Financing health care for adolescents: a necessary part of universal health coverage. HLSP/Mott MacDonald, 10 Fleet Place, London EC4M 7RB, England

¹⁸ See for example, Coarasa, J. and J. Das, 2015. Primary Care for the Poor: the potential of micro-health markets to improve care. Viewpoint, Public Policy for the Private Sector. The World Bank Group. Note Number 345.

4. **Payment.** Provider payment must be designed to balance contraceptive choice for clients. Overcoming much of the provider bias in limiting contraceptive choice requires paying for the service requirements of delivering different contraceptive methods, including appropriate time for counselling. While short-term methods can be efficiently financed through commodity financing, differential case-based payments are best suited to long-acting reversible and permanent methods.

Figure 2 – ‘4Ps’ matter in an effective financing model for contraception



Conclusion

What we learned

In summary, the HFAs have taught us that in most of the countries where MSI operates, there is a general absence of contraception from private insurance coverage and employer health plans. All countries assessed had public financing approaches in place for contraception. However, within these, we saw that financing contraception was often focused on the commodity and not the service. We saw that payments to providers tended to be either too low powered or too high powered - both approaches showed the signs of provider bias and eroded choice. We observed that maternal health and contraception financing reforms have not stayed hand in hand. And we learned that, in general, midlevel private providers are not accessing public financing flows despite the role they can play to extend UHC coverage and reduce unmet need for contraception.

We conclude that UHC financing reforms have to bring together four key elements to make contraception work to address unmet need. The right people covered, the right package including contraception, the right providers contracted, and the right balance in payment approaches that will overcome provider bias in contraceptive methods.

Where to go from here?

From today's vantage point, UHC is not all about domestic public financing. Achieving UHC requires significant donor support, at least in the short to medium term, in many countries. According to WHO, only eight low-income countries will be in a position to fully finance UHC from domestic resources in 2015.¹⁹ Donor and domestic financing therefore should not be viewed as one or the other, but how one builds on the other.

In all transitioning contexts, MSI believes we cannot take our eye off delivering high quality services today for our client. She needs results now. But we believe we must do this important work while being mindful of developing the financing models that will work for tomorrow. If we do not, we risk sending signals to public authorities that contraception will always be taken care of by someone else, and we will not be doing our part to embed what we know about good practices for financing it.

In response, Marie Stopes International is increasingly looking to build domestic financing transition into our service delivery work so that we support the journey to UHC. In some instances, this will mean proving the concept of case-based payments that balance contraceptive choice for the poor, such as through voucher programmes. In others, we will be working with donors and governments to blend donor funds with national UHC funds (with some prioritization for contraception) in order to strengthen national purchasing systems. In yet others, we will more explicitly demonstrate how to handle contraception under NHIs as a form of pilot. In this era of domestic health financing reforms, we cannot afford to have so few examples of effective contraception financing in countries where unmet need is urgent.

Post-script – what did we learn about abortion?

MSI HFAs also examined financing approaches to abortion in relevant countries. While contraception featured in all public financing systems, but very rarely did comprehensive abortion care (only two of 20 countries surveyed had any public financing for CAC, although seven had legal frameworks for CAC. A further two had provisions for financing CAC but these were not functioning in practice). The exception was post-abortion care, where public resources were frequently directed to the treatment of complications. In other words, **we found that abortion financing was almost all out-of-pocket unless it pertained to post-abortion complication treatment.**

We did not make a similar set of recommendations for UHC and abortion services. Sadly, safe abortion is not on any track of being able to leverage UHC in most of the countries we assessed. Providing recommendations at this time would not be realistic given the wider legislative, regulative and financing situations these services face.

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¹⁹ World Health Organization (2010) 'Constraints to scaling up the health Millennium Development Goals: costing and financial gap analysis' Background document for the Taskforce on Innovative International Financing for Health Systems, World Health Organization: Geneva.