SHOPS PLUS

Integrating Family Planning into Universal Health Coverage Efforts

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Summary

The global movement to reach universal health coverage presents opportunities to advance family planning goals. The family planning community has a keen interest in whether and how the full range of contraceptive services can be made accessible, particularly to underserved populations such as youth or the poor, within broader initiatives that aim to achieve universal health coverage. This brief describes common approaches used to finance health within the context of universal health coverage and the significance of these approaches for family planning. The authors focus on the role of private health providers and the mechanisms used to pay them. Making progress toward universal health coverage and satisfying unmet need for family planning is a long-term process, but one that can be accelerated. Advocates can champion better coverage of family planning by building the evidence base, promoting inclusion of private providers, and gaining a better understanding of the concepts and language of health financing.

Keywords: Family planning, heath financing, universal health coverage

Photo: Jessica Scranton

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Integrating Family Planning into Universal Health Coverage Efforts

Countries around the world are working to achieve universal health coverage (UHC). The movement aims to ensure that all people can access quality health services without financial hardship. Commitments by countries to achieve UHC are grounded in the principle that health, including family planning, is a human right and that investments in health pay human and economic dividends. Health underpins economic growth and equality, particularly the health of women, girls, and the poor (Naik et al. 2014). The inclusion of UHC as a health-related target under the Sustainable Development Goals adopted by the United Nations in 2015 was a major milestone for the movement, cementing its growing importance and visibility.

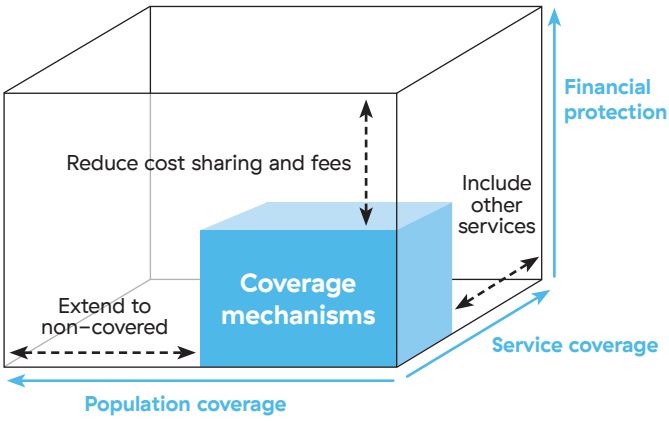
Vouchers are one health financing approach that can improve access to family planning services.

An opportunity to advance family planning goals

The UHC movement presents potential pathways for attaining family planning goals. Family planning advocates are evaluating opportunities to integrate, scale up, and sustain coverage of family planning via financing mechanisms, such as insurance, and to coordinate with broader efforts to expand coverage of preventive and primary health services.

This brief describes common approaches used to finance health within the context of UHC as well as the significance of these approaches for family planning. These approaches are called "health financing programs." The authors emphasize the role of private health providers and the mechanisms used to pay them.

Figure 1. Three dimensions of universal health coverage



Source: Adapted from WHO (2010)

There is no single, direct route to reach UHC; expect detours

The World Health Organization (WHO) depicts UHC along three main dimensions (Figure 1):

1. Population coverage: Who, and how many are covered?
2. Service coverage: What services, including those for family planning, are covered? Which providers will deliver the services, and is the quality acceptable?
3. Financial protection: To what degree are the costs of health services covered? How much must people pay for health care services out of pocket, potentially causing hardship or even impoverishment?

It's easy to agree that UHC is a laudable goal. What is challenging is agreeing on how UHC will be achieved, and in particular how it will be paid for. The details of specific approaches to UHC are often hotly debated and politically driven. Crucial questions concern how much interventions will cost; how they will be financed; who and what services will be covered; what governance and operational models will be used; and what the implementation details are, such as timing. Recent research led by WHO presents new estimates of the investment countries need to make to achieve health-related targets specified under the Sustainable Development Goals, and the potential benefits of improved health outcomes if these goals are attained by 2030. The estimates confirm that major funding gaps must be closed to attain UHC, and in particular to scale up service coverage. More funding per capita may be necessary than previously estimated. In addition, countries must continue to grapple with how to integrate and scale up programs for family planning and other health services in ways that are politically acceptable, equitable for citizens, and sustainable. Despite these challenges, even the poorest countries can make progress to provide universal coverage of essential services (Stenberg et al. 2017).

In this context, it is no surprise that pathways to UHC vary by country and progress is mixed. Typically, countries implement multiple health financing programs simultaneously. They tailor as they go to fit their own circumstances, needs, and capacities (Lagomarsino et al. 2012). The mechanisms they choose aim to contribute to health goals, often by targeting specific population groups or by pooling health risks to reduce the financial burden on citizens when they need health care.

Regardless of the pathway chosen, making progress toward UHC and providing universal access to family planning is an immense and long-term challenge. There are many reasons for this, including:

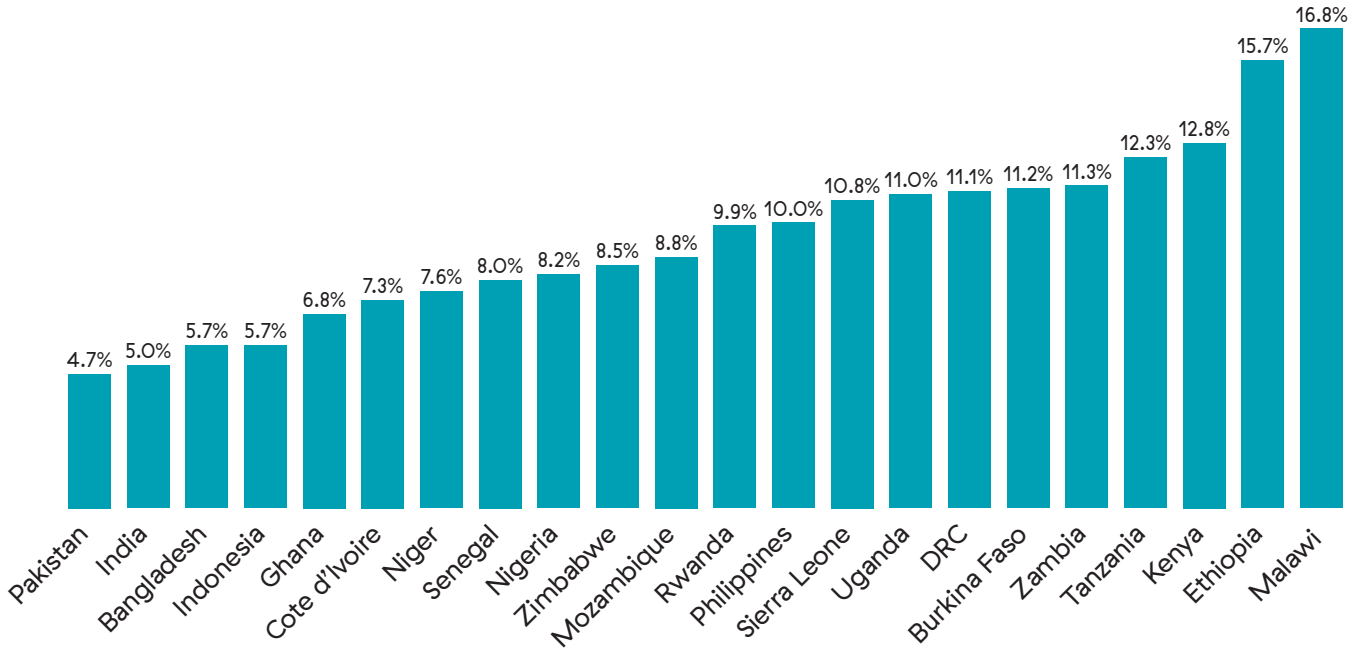
1. **Insufficient financial resources.** Countries struggle to mobilize and sustain sufficient funding to deliver essential services, and to distribute the funding in an equitable and efficient manner. In the 2001 Abuja Declaration, heads of state from African Union countries pledged to spend 15 percent of their budgets on health. Ten years later, 26 countries had increased their expenditure on health, though only one, Tanzania, had met the 15 percent target. Another 11 countries had decreased their relative spending on health, while the remaining nine did not show a trend up or down (WHO 2011). Looking at USAID's 22 priority countries[1] for family planning, which span Africa and Asia, government spending on health ranges from 4.7 percent in Pakistan to 16.8 percent in Malawi. Spending by 20 of these countries falls short of the Abuja target (Figure 2).

[1] *As of May 2017, USAID supported family planning programs in 22 priority countries.*

A family planning counseling session in India

Photo: Jessica Scranton

Figure 2. Health as a share of total government expenditure



Source: World Bank (2014)

2. **Challenging and constant tradeoffs**. As noted, coverage is a multi-dimensional concept. Increasing population coverage, service coverage, and financial protection requires difficult tradeoffs to deploy limited resources. For example, programs must decide whether to cover more people with fewer services, or to cover more services at a lower level of financial protection—or some other variation. Countries must also use limited resources more efficiently—essentially extending coverage for the same cost (WHO 2010). They attempt to do so using multiple levers. These include adopting approaches for more strategic purchasing of health services that introduce new provider payment mechanisms, task shifting among health workers, and improved procurement and use of medicines and commodities. Difficult tradeoffs sometimes occur at the expense of family planning. For instance, a full range of family planning methods may not be covered in a benefit package so that other, more costly services can be covered.

3. **Political and social realities**. The political nature of UHC affects implementation choices and results. Governments may elect to prioritize less cost-effective but more urgent, and often life-saving, curative services such as cancer treatment or hemodialysis at the expense of prevention and primary care services—including family planning (Wright and Holtz 2017). Coverage of family planning services under health financing programs and access to those services also may be subject to other limitations that arise from religious, gender, and cultural preferences and norms.

4. **Focus on the formal sector**. Health financing programs, in particular insurance schemes, often begin by covering civil servants or other formally employed workers and their families. Formal sector households are easier to identify, enroll, and collect contributions from. Typically in low- and middle-income countries, the formally employed represent a minority of the population, and those who are better off. Large numbers of people such as day laborers, traders, or subsistence farmers who are informally or self-employed often come

from poorer, vulnerable households. These informal sector households and youth can be left out, limiting population coverage.

5. **Focus on curative services**. As noted previously, political realities often produce health financing programs that emphasize coverage of inpatient and other curative and costly services. Primary care and medicines may be excluded or covered at a lower level. In addition, insurance schemes may focus coverage on more costly curative services because these services occur less frequently, are less subject to fraud, and cost less to manage.

6. **Limited access to private providers**. Some health financing programs cover only services obtained from public providers, and not services obtained from private providers. However, the capacity and quality of services in the public sector are often limited, and citizens—even the poor—choose to obtain services from private providers and pay for them out of pocket.

Importantly, programs designed to extend coverage may expand more slowly or become stalled, affecting one or more of the dimensions of coverage (population coverage, service coverage, and financial protection). Additional challenges may arise. For example, programs may struggle to pay salaried or contracted providers adequately and on time, exacerbating shortages of human resources for health, and limiting funding available to the health system to expand and maintain needed infrastructure.

Programs that finance health services

UHC can be financed through a variety of approaches. These include publicly financed provision of services, insurance, and vouchers (Box 1).

Box 1. Health financing programs that support UHC

Publicly financed provision of health services

- Government facilities dominate service provision; private providers may also be contracted
- Financed through general tax revenue (e.g., value-added tax); may be augmented by donor funding
- Services can be free, or individuals may pay user fees out of pocket

Government-sponsored health insurance

- Financed though premiums paid by employers and/or individuals
- Government subsidies can help cover the poor and fund the program
- Enrollment may be voluntary or mandatory; programs may target a specific group (e.g., civil servants)

Vouchers

- Demand-side financing instrument: government (or donor) issues a voucher to beneficiary at little to no cost to obtain a priority service such as family planning or maternity care
- Often target poor, vulnerable populations

Source: Adapted from Holtz (2016)

In the first approach, public funds are used to pay for health services provided to citizens for free or at reduced cost. Health insurance is a second financing approach; it enables the cost of health events incurred by some members of the insurance program to be spread across all members. Insured members make regular prepayments, called premiums or contributions, to the pooled fund that pays the cost of the covered health care services that members use. These pooled funds replace some or all of the often burdensome cost of services otherwise borne by individuals. In this way, the healthy subsidize the sick, and the likelihood of catastrophic health care spending by individual members is reduced.

Many countries are implementing or plan to implement government-sponsored insurance programs as a core component of its strategies to reach UHC. In some low- and middle-income countries, such programs now serve millions of people, including the poor. Health insurance also can be offered by private sponsors such as licensed insurance companies or community organizations. Government-sponsored programs are a core component of country strategies to reach UHC. While privately sponsored health insurance programs can complement government programs, they generally target higher-income households and serve small numbers of people.

While insurance programs often exclude family planning at the onset, they present an opportunity to shift from separately financed "vertical" family planning programs to broader programs that integrate and sustain family planning services and financing.

Vouchers and conditional cash transfer programs constitute a third financing approach. These programs are important demand-side financing mechanisms, whereby greater purchasing power for family planning and other health services is shifted to clients. These mechanisms can increase access to family planning, especially by targeted vulnerable groups; they function as stepping stones

Teblets Berehe holds her green Community–Based Health Insurance card in Kilite Awlalo, Tigray Region, Ethiopia.

Photo: © 2016 Habtamu Bogale/ Abt Associates, courtesy of Photoshare

to introduce and expand health financing programs, too. At the same time, multiple concurrent programs can hinder progress toward UHC. Fragmented programs can increase cost and inequity among groups who contribute at different levels, and in return receive different levels of coverage and access (Evans, Beyeler, and Beith 2015).

Growing focus on government–sponsored health insurance

Increasingly, countries are pursuing government-sponsored health insurance schemes as a means to promote UHC. As of May 2017, 14 of USAID's 22 family planning priority countries operated some form of government-sponsored health insurance (Avenir Health 2016a). Most of the others (Zimbabwe and Uganda are exceptions) intend to introduce health insurance programs in the future, demonstrating their commitment, but still nascent progress. Population coverage—how many, and which groups of people are enrolled—in current programs varies, with many still working toward covering a majority of citizens. Only two of the USAID priority countries, the Philippines and Rwanda, operate health insurance programs that cover nearly all of their populations. Both of these programs have been expanding coverage for decades. Since 1995, the Philippines government has operated the Philippines Health Insurance Corporation (PhilHealth), the country's national health insurance scheme, as its primary pathway to achieve UHC. As of 2016, PhilHealth covered 91 percent of its eligible population (PhilHealth 2016), with benefits for some but not all family planning services.[2] The government of Rwanda began developing its community-based model for national health insurance in 1999; as of 2013, 74 percent of the population was covered (Management Sciences for Health 2016).

[2] PhilHealth excludes removal of IUDs and implants, and oral contraceptive pills except the first month for postpartum clients (commodities are free at public facilities), according to a SHOPS Plus assessment.

Comparison of provider payment mechanisms

	Fee for Service	Capitation
Timing of payment	Retrospective (paid after service is provided and claim is made)	Prospective (paid at the start of each defined period, e.g., per month or per year)
Trigger for payment	Service is provided	Client is enrolled with a provider
Basis for payments	Rate per service (or case or day)	Rate per person (or family) per period for a defined set of services
Provider revenues are determined by	Number of services delivered at X rate per service	Number of enrollees at X capitation rate per enrollee
Financial risk associated with service use	Purchaser bears financial risk (amount will vary based on basis of payment)	Provider assumes financial risk

Financing family planning in the context of financing UHC

Country approaches to financing family planning also vary. They can operate as part of, or in parallel to, the broader initiatives described earlier. Of current interest within the family planning community is whether and how the full range of family planning services can be made accessible, particularly to underserved populations such as youth or the poor, and unmet need can be addressed within the context of broader initiatives that aim to achieve UHC. Family planning has historically often been delivered via standalone, or vertical programs, funded by donors. A strength of these programs is that they capture and retain dedicated technical expertise and funding. However, a vertical family planning program that offers free or highly subsidized services financed by an external funder can have the unintended effect of creating a disincentive for a publicly financed program to cover family planning services (Box 2). Nevertheless, government purchasers of health care have begun to recognize that vertical programs are vulnerable as their countries "graduate" from donor funding and are expected to finance family planning and other health services increasingly from domestic sources.

Box 2. Family planning and public health insurance in Ghana

In Ghana, family planning has historically been financed by the government, out–of–pocket spending, and donors such as USAID. To increase uptake of contraception, family planning services were included in the National Health Insurance Scheme's benefits package legislated under the 2012 National Health Insurance Act. The act has yet to be fully implemented and family planning services are still not integrated into the scheme's benefit package. Nonetheless, the legislation presents an important opportunity to not only increase the availability of family planning services, but also to mobilize domestic resources and decrease donor dependence (Chaitkin et al. 2015).

Countries including Bangladesh, Malawi, and Uganda do not currently sponsor health insurance, but they operate standalone programs that include family planning and contract private providers to provide family planning services. For example, Bangladesh runs a publicly financed reimbursement scheme that provides compensation to acceptors of long-acting reversible contraceptives (LARCs) and permanent methods. Malawi contracts with private providers through service level agreements with the Christian Health Association of Malawi (CHAM) to deliver health services, including family planning, in hard-to-reach areas. Uganda operates large-scale family planning voucher programs that help alleviate the financial burden associated with accessing family planning services. Clients under this scheme are paid for lost wages when accepting permanent methods or receive a transportation subsidy when accessing LARCs (Avenir Health 2016f).

Progress toward universal health coverage is generally more advanced in Latin American countries. Above: a nurse from the Paraguayan Center for Population Studies discusses family planning options with a young female client.

Photo: Martha Merida

Covering family planning in insurance schemes

Family planning services are often excluded from health insurance benefit packages. Exceptions to this are found in many Latin American countries, where progress toward UHC is generally more advanced (Box 3). Research by Avenir Health found that just six of the 14 government-sponsored health insurance schemes in USAID family planning priority countries include family planning in their benefit package (Box 4). Countries might not include family planning for a variety of reasons. As has been noted, family planning is often financed by donors through vertical programs, providing a disincentive to the government to integrate family planning into other financing programs. Insurance programs also tend to cover costly health events, such as hospitalizations. Family planning is preventive and lower in cost than most other services.

Box 3. Family planning and UHC in Latin America and the Caribbean

Latin America and the Caribbean is home to more established, larger–scale, government–sponsored insurance programs that support achieving UHC. Enrollment is nearly universal in Chile, Colombia, and Costa Rica, and most programs across the region include all or nearly all family planning methods in their benefit package.

While progress has been made in terms of population coverage and the contraceptive prevalence rate (CPR), barriers to family planning still exist, especially for marginalized groups, the uninsured, and the poorest women. On average, the modern CPR is 20 percent lower among indigenous women, 5 percent lower among the uninsured, and 7 percent lower among women in the poorest wealth quintile (Fagan et al. 2017).

Other regions, in particular Africa, may emulate the achievements of Latin America and the Caribbean over time as they make progress toward UHC. A lesson learned from this more mature region is that programs supporting UHC and universal access to family planning will continue to have gaps, particularly in reaching vulnerable populations.

Box 4. Six public health insurance schemes that cover family planning

According to research by Avenir Health, 14 of USAID's 22 family planning priority countries operate some form of government–sponsored health insurance: Cote d'Ivore, Senegal, Ethiopia, Ghana, Kenya, Mozambique, Nigeria, Rwanda, Tanzania, Zambia, India, Indonesia, Pakistan, and the Philippines.

However, only six of 14 government–sponsored health insurance schemes include family planning in their benefit package: Ghana, India, Indonesia, Kenya, Philippines, and Rwanda. This list, however, is misleading; family planning might be included only on paper. For example, Ghana's family planning benefits package legally includes family planning, but the package is yet to be implemented. In the Philippines, all methods are technically covered, but currently there is a restraining order against providing implants.

Source: Avenir Health (2016a)

The role of private providers

Private providers are an important source of care in most countries. Although family planning is usually free or nearly free when obtained in the public sector, the reality is that substantial numbers of people, including the poor, seek services from private providers. Reasons include stockouts, limited geographic access, and poor quality within the public sector. The perception of privacy in the private sector is another reason clients chose it, often coupled with more convenient, quicker access. According to a 2015 study by Campbell and colleagues on private sector provision of family planning, the private sector provides 37 percent of family planning services. Of this share, over half (54 percent) of family planning services are provided by medical providers, 36 percent by specialized drug sellers, and 6 percent by retailers. Research from the USAID-supported Strengthening Health Outcomes through the Private Sector (SHOPS) project showed that over a 20-year period, the private sector was the source of family planning for just under half of contraceptive users in Latin America and the Caribbean as well as Asia. In sub-Saharan Africa, the private sector share was just under a third (Ugaz et al. 2015). SHOPS research also shows that private providers are an important source of care for the poor (Figure 3).

Figure 3. Use of private providers for modern family planning methods by two lowest-wealth quintiles (%)

Source: SHOPS Project (2014)

Private providers are engaged to deliver family planning services under some health financing programs. Two voucher programs in Uganda use private providers to deliver family planning services: the Reproductive Health Voucher Project and the Long Term Family Planning Methods project (via BlueStar franchise clinics). In Ethiopia, the NGO Family Guidance Association of Ethiopia has agreements with private clinics to provide contraceptive commodities free of charge to clients. NGOs play a substantial role in the delivery of health services to rural areas and urban slums in Bangladesh (Avenir Health 2016b).

Small- and medium-sized private providers in particular can enable health financing programs to expand access to services. Many people, particularly the poor, seek care from these providers, often located in their communities. However, these providers remain largely untapped by health financing programs. Small- and medium sized providers comprise large numbers but can be challenging to catalogue, organize, and monitor. Instead, better known, larger private providers such clinics or hospitals tend to be contracted by health financing programs. Larger private providers also are often well regarded. They can be more efficient to contract, in effect offering "one-stop shopping" for a purchaser. However, they may be more expensive.

Just because it's covered, doesn't mean it's covered

The capacity of countries to measure progress toward UHC is improving (WHO 2015). However, when it comes to health coverage, what is stated on paper and in policy may be quite different from what is happening on the ground. In other words, it is not enough to know that a person is covered by a program, and that services covered under that program include an adequate level of financial protection.

Small– and medium–sized private providers can enable health financing programs to expand access to services. Right: A physician in Nigeria.

Photo: Mike Blyth

Clients choose contraceptive methods based on multiple factors, including financial implications.

Photo: © 2017 Riccardo Gangale, courtesy of Photoshare

A more nuanced assessment of coverage requires deeper analysis. For example, researchers at the Institute for Health Metrics and Evaluation suggest that *effective* coverage, a more holistic metric that considers population need, use, and quality of services, is a feasible and more accurate way to measure progress toward UHC (Ng et al. 2014). Effective coverage of family planning in health financing programs will depend on an array of potential underlying and interacting factors that go beyond the three broad dimensions of UHC depicted in Figure 1 on page 2 (population coverage, service coverage, and financial protection). These factors include the program's design—its provider payment mechanisms, for example, and which providers it contracts to deliver services; the capacity of the health system to provide quality services; the country's policy, social, and economic environment; and the treatment-seeking behavior and preferences of citizens themselves.

Financial terms for clients and providers matter

The amount of money paid for services, and who pays that money—the client, or a third party such as an insurance or voucher program—can affect coverage, choice of method, and choice of provider.

One influencer of coverage is which health providers participate in provider networks. Another is the amount and way in which they are paid to deliver covered services under health financing programs. The importance of rates and payment mechanisms as well as the role of politics were reinforced in findings from research presented at a consultative meeting on supporting family planning within UHC initiatives (Avenir Health 2016g, Mazzilli et al. 2016). The meeting was hosted by the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project in collaboration with the Bill & Melinda Gates Foundation and USAID in October 2016. Experts at the meeting noted that family planning advocates have much to learn about the nexus between provider payment approaches, client cost sharing, provider network composition, and other components of health financing programs. A key takeaway from the meeting was that the global health community needs more evidence and documented lessons across a greater number of settings to understand how these factors enable or inhibit access to quality family planning and other health services.

Clients choose and providers recommend contraceptive methods based on multiple factors such as clinical considerations, availability, religious and cultural beliefs, adequacy of knowledge, effectiveness of counseling (for clients)—and financial implications. Theoretically, all other things held equal, clients—especially those who are poor—are likely to choose methods (and providers) that are less expensive for them. Research from the SHOPS project shows a statistically significant

Financial factors affect where a client chooses to obtain a service.

Photo: Jessica Scranton

association between wealth and use of long-acting and permanent methods (LAPM). Poor women tend to use short-acting methods, while wealthier women tend to use LAPM (Ugaz et al. 2016). Financial factors also affect where a client chooses to obtain a service. Out-of-pocket costs can be higher when services are obtained from private providers compared to public providers. Furthermore, if out-of-pocket costs are proportionate to the cost of a service (e.g., short-acting methods cost clients less than LAPM), clients may choose a private provider for short-term methods that are more affordable, but seek more expensive methods such as LAPM from public providers, where the service may be free or nearly free (Ugaz et al. 2013).

Financial terms matter for providers, too. Specifically, payment mechanisms and rates are among the factors that influence providers' willingness to participate in health financing programs, and when they do, whether they have a financial incentive to provide one method over another. The viability of given payment approaches and rates will vary by provider, too, because this will depend on the provider's cost structure and business objectives. For example, a certain amount in payment for a family planning service may be attractive to an independent midwife operating a small practice. But that same amount may be judged inadequate by a larger clinic that operates with a higher cost structure due to a more intensive staffing and service mix, or by a clinic that seeks to earn a certain level of profit to support future expansion and to attract qualified staff. Different providers also might view a particular payment mechanism and rate differently based on the proportion of their services that would be paid subject to that particular payment mechanism.

Small- and medium-sized practitioners in particular can find it difficult to participate in health financing programs. Research by Marie Stopes International found that private providers are often unable to satisfy the requirements to contract with government-sponsored health financing programs (Mazzilli et al. 2016). In Indonesia, one potential barrier for private midwives to contract with the national health insurance scheme called Jaminan Kesehatan Nasional (JKN) is the requirement to set up a memorandum of understanding with a community health center (Avenir Health 2016d). The memorandum links private midwives who often work independently to a referral facility in case they need additional assistance. However, the agreement includes a requirement for private midwives to share a percentage of their revenue with the community health center. Further, payments from JKN are lower than what many private midwives receive otherwise. As a result, midwives may perceive it is not to their advantage to contract with JKN. In Kenya, private providers can contract with the National Health Insurance Fund (NHIF), but they struggle to do so because of multiple licensing requirements, challenges to access credit, and insufficient payments (Avenir Health 2016e). Population Services Kenya and Marie Stopes Kenya broker the contracting of private providers affiliated under their social franchises with the NHIF to reduce transaction costs for individual members to become accredited. This approach is also more efficient for the NHIF. The government of Ethiopia recognizes the importance of the private sector, but has yet to define the role the private sector will play in the pending social health insurance program for formal sector households, which is intended to complement community-based schemes the government is now scaling up across the country for informal sector households. The Ethiopian government is also weighing what payment mechanisms and payment rates it will offer private providers under social health insurance. One option it is considering, as an incentive to contract, is to pay private providers a 25 percent "top up" to existing fees paid to public facilities (Avenir Health 2016c).

A midwife from East Java, Indonesia

Photo: © 2005 Catherine Harbour, courtesy of Photoshare

The rise of strategic purchasing

An important aspect of health financing programs is the approach they use to purchase health services from providers. Strategic purchasing refers to a shift from a traditional, reactive bill-paying or line-item budget approach, to proactive ones whose design and implementation are evidence-based and support achieving health system objectives.

Family planning services have historically been financed using *input-based methods*. These include direct funding through line-item budgets for staff salaries, buildings, equipment, and supplies at publicly funded providers, or donor programs funded through grants or cost-reimbursement contracts, often in partnership with nonprofit providers. However, the capacity of health financing programs to strategically purchase health services is growing. Supported by more robust information and monitoring systems, and under relentless pressure to expand coverage with limited resources, programs in countries such as Ghana, Indonesia, Kenya, and Tanzania are experimenting with purchasing mechanisms that encourage quality and efficiency, and reduce improper incentives for unnecessary utilization or fraud.

Any purchasing approach will have pros and cons for each stakeholder. User fees at public providers can raise revenue for the provider or government, but they also create financial barriers for clients to access care. These barriers create inequity, as they disproportionately affect the poor or the sick.

Provider payment mechanisms

A dominant provider payment mechanism in use is fee-for-service, and an emerging one is capitation; both are discussed in this section. It is important to understand how payment mechanisms perform in a given context and how they affect services, such as family planning, and providers. For this reason, countries are experimenting with different payment approaches and may blend two or more payment mechanisms.

Fee-for-service: Payment by service, case, or day

Fee-for-service is a common payment mechanism across economic sectors. A simple example of it is buying a meal at a restaurant—the menu offers a range of items, each with a set price. The customer chooses items from the menu and, after the meal, pays the expected bill. Purchasing health care is more complicated. Clients, or those who purchase care on their behalf, have asymmetric information—meaning it is difficult for them to determine when they first seek care, what and how many services they will need, and to judge their quality, clinical efficacy, and cost-effectiveness.

Fee-for-service payments are triggered when services are delivered. At the most basic level, fee-for-service payments are made for each service rendered or material supplied during a health encounter. For example, using a service-level fee-for-service approach, a client who chooses oral contraceptives would pay for a consultation and for a supply of pills.

There are other variations of fee-for-service payments. They can be based on the number of cases treated or the number of days delivered (for inpatient services). A case refers to a diagnosis or condition. Each case is associated with a package of services commonly required to treat that diagnosis or condition. For example, to treat a case in which a client wishes to avoid pregnancy, the associated services would include counseling for family planning plus provision of a family planning method (if chosen). To treat a pregnancy case, the expected services comprise antenatal care and delivery.

Case rates can be used for inpatient and outpatient services. With case rates, it is the diagnosis or condition that determines the payment and not the actual number or type of services delivered to treat that case.

Additionally, fee-for-service payments may also be structured on a per-diem basis for inpatient services. With per diems, it is the length of stay that determines the payment and not the diagnosis or the actual set of services delivered.

Different forms of fee-for-service payment (by service, case, or day) provide different financial incentives for providers to deliver more or less, or different services, affecting quality of care and efficiency. Case rates provide a financial incentive for the provider to treat cases that pay more. A case rate payment approach also provides a financial incentive to provide fewer services per case, since the payment per case is fixed. Per diems offer to the provider a financial incentive to admit the patient and to extend the length of stay while reducing the number and intensity of services provided each day, since the payment per day is fixed.

Fee-for-service payment at the service level remains a common payment approach in family planning programs, with increasing use of case rates (Box 5). Fee-for-service payments at the service level are the most precise way to pay for actual services delivered for a given health encounter. A fee-for-service approach can also be chosen to encourage delivery of priority services. This could apply when priority services are not evenly used among a population, such as maternal and child health services and family planning, or when the services are expensive or seldom used. If accurate and clinically appropriate, service-level payments will be lower for a simple case than one with complications, or where the patient presents with multiple medical problems. However, they give providers an incentive to provide more, and more expensive services, fueling costs but not necessarily improving outcomes. This is particularly true when a third party such as an insurance scheme is paying for the services on behalf of a client. Fee-for-service payment arrangements are also subject to fraud, such as billing for a service (or case or day) not rendered at all.

Box 5. Fee-for-service payments in family planning programs

Payment arrangements for family planning services vary widely. Through voucher programs in Uganda, private providers are paid a fee for service depending on a family planning method provided, which can range from $0.73 to $4.60. In Kenya, permanent family planning methods are included under inpatient contracts and providers are paid a fee for service. In Bangladesh, providers are paid $5.00 per permanent method case and less than $1.00 per implant or IUD insertion under the reimbursement scheme.

Source: Avenir Health (2016 b, e, f)

Capitation

An alternative to fee-for-service payment is capitation. Capitation refers to a prospective payment made to providers on a per-person, per-period basis for a defined set of services. Capitation is well suited to pay for frequent, predictable, and commonly used services such as primary care, especially when the capitated population is sufficiently large and diverse. Capitation places the provider, and not the purchaser, at risk for the amount and type of services used, thereby creating better alignment of financial incentives between health care purchasers and providers. This is a key difference from fee-for-service approaches, where, depending on the approach, the purchaser bears all or some of the financial risk of utilization. As such, capitation requires a total paradigm shift by providers to effectively manage their practices under a different payment approach with different financial incentives.

Financial incentives change for providers when capitation replaces fee-for-service payment approaches. Whereas fee-for-service payments are triggered by service use, capitation payments are triggered by *assignment* to a provider. For example, a capitation payment can be made on a per-member per-month basis, or, alternatively, a per-household per-year basis. These payments do not vary based on use. As a result, the financial incentive with capitation is for providers is to be assigned more patients, but to use fewer and more cost-effective services per patient.

This assessment, however, is simplistic. In reality, the factors that drive service delivery are complex and include many non-financial incentives, including the desire and capacity of providers to deliver quality care, disease burden, availability of commodities, and health-seeking behavior. Financial incentives themselves are also complicated and not well understood in different contexts.

One critical aspect of capitation is what services are included in the capitation payment. If family planning services are included in a capitation payment for a set of primary care services, all other things held equal, providers would have a financial incentive to provide short-acting methods (or none at all) since those methods are the most efficient to provide. If family planning services were included under a capitation rate that includes maternity care, the financial incentive for family planning would change when considering its potential to avert unwanted pregnancies, at least over a longer time period. In addition, the referral mechanisms for services not covered under capitation, changes in subsidies and cost inputs, enrollment and retention of patients, and clinical orientation are among other factors that can influence how providers respond to the financial incentives under capitation.

In several countries, a health financing program is gaining experience with capitation to pay for family planning services. Indonesia's JKN scheme pays for IUDs under capitation at the primary level, but it is also paying fee for service using case-based payments at the secondary and tertiary levels (Avenir Health 2016d). If only financial incentives are considered, a primary care provider could have an incentive to refer a patient for an IUD insertion to a higher-level facility, since the capitation payment for the primary care provider will remain constant regardless of services delivered. Furthermore, the scheme is learning how adequate the capitation payment will be to compensate providers for delivering the range of services, including family planning, specified under the capitation payment. Similarly, in Kenya, the NHIF is now using capitation to pay contracted primary care providers. This means that family planning services they provide won't generate additional revenue for them (Avenir Health 2016e).

Women in Rwanda hold mutuelle cards. Rwanda has a community–based model of national health insurance that covers 74 percent of its population.

Finally, not much is known about how the amount or rate paid under a particular capitation approach influences use of services. In theory, the higher the rate, the more a provider should have sufficient revenue to provide needed services, with good quality. One of the pitfalls of capitation is that the capitation rate is an estimate of the amount of money needed to cover the cost to provide covered services to patients. Use of health services varies greatly among individuals, however. Thus, a capitation approach can in effect overpay some providers and underpay others, based on the use and mix of services delivered to their assigned clients. When considering a voluntary service such as family planning that is predominantly used by women, a network provider that provides a full range of family planning methods could attract a mix of patients who use many family planning services, yet receive the same capitation payment as another provider who provides fewer family planning services. This is one argument for "carving out" family planning from capitation payments for primary care, and paying for it on a fee-for-service basis (whether with case rates or at the service level).

The intersection of payment approach and choice

The client's right to make an informed decision regarding whether to use contraception, and if so, which method, remains a central tenet of family planning. In theory, equivalent and feasible financial terms across methods for providers and clients should promote unbiased provision of methods and choice for clients. As described earlier, financial incentives resulting from the payment approach, the applicable rates, or out-of-pocket costs borne by clients can influence the extent to which people can genuinely choose the family planning method of their choice. Choosing an intervention occurs with other health needs too, where different interventions are possible and one must be chosen based on the patient's needs and preferences in consultation with a health provider. For example, some orthopedic conditions may be treated by a surgical or a non-surgical intervention.

Photo: Jeanna Holtz

Implications for Family Planning

Progress toward the realization of UHC and satisfying unmet need for family planning can be accelerated. Platforms like the Global Financing Facility (see text box) help countries mobilize and sustain critical resources to fund these efforts. As more countries expand demand-side financing mechanisms such as health insurance or vouchers, family planning advocates can do much to champion the case for effectively covering family planning.

1. **Build the case**. Greater evidence on what works and does not work is the foundation of a persuasive case for including family planning in health financing programs, and will inform how best to do this. Owing to the limited evidence on the effect of health financing programs on family planning, WHO has generated evidence through systematic reviews of pay-for-performance, conditional cash transfers, vouchers, user fees, and community-based financing (Ali and Lissner 2016). Areas for further study regarding the effect of payment mechanisms for family planning include:

    a. More rigorous investigation about the effect of capitation on provider behavior and use of the range of family planning services to better understand whether and how to use capitation with, or in place of, other payment options for family planning.

    b. Deeper analysis of the effect of out-of-pocket costs borne by clients on their use of family planning methods and their choice of providers to build understanding of how to design sustainable, equitable programs. For example, how does client uptake and choice of method vary when a client is financially indifferent to the method she chooses? Conversely, what is the effect of "uneven" out-of-pocket costs on family planning uptake and method choice?

2. **Engage private providers**. Making progress toward UHC—including increasing financial risk protection and access to services, including family planning—is enabled through a total market approach that considers the potential contributions of public and private providers. Family planning champions should advocate

Global Financing Facility

The GFF is a platform that helps mobilize domestic financing, external support, and innovative sources (including the private sector) for reproductive, maternal, newborn, child, and adolescent health. The platform encourages countries to build investment cases that help prioritize a set of investments to achieve improvements in these health areas. The GFF also helps countries build health financing strategies to promote financial sustainability of such efforts. This begins with an assessment of all aspects of health financing in the country.

Source: Global Financing Facility website, globalfinancingfacility.org

for including small- and medium-sized private providers representing various cadres in health financing programs to reach larger numbers of underserved people.

3. **Strengthen voice**. Family planning advocates must argue for *effective* coverage of family planning in insurance or other health financing programs. Their arguments must resonate with stewards of the health system and other functions of government, and be heard amid voices conveying other interests. For example, special interest groups such as hospitals and patient advocacy groups (e.g., for cancer) advocate for coverage of secondary and tertiary health care services that may mean life or death for the patient; insurance providers are inclined to cover "insurable events" such as hospitalizations that are infrequent, random and financially catastrophic in nature; they may exclude primary care (and some, or all family planning services) or not contract with small- and medium-sized providers for fear of driving up administrative costs, or increasing exposure to fraud or over-use.

   There is mounting pressure to operate efficient, sustainable programs that improve health and provide financial risk protection in support of UHC and universal access to family planning. Advocates of family planning can continue to build the evidence base on the health and financial benefits of family planning, for instance, demonstrating how to include family planning within larger financing programs that are efficient, equitable, and cover large numbers of people. In all cases, family planning advocates must become more fluent in speaking the language of stakeholders who are not family planning experts, but who are accountable for broader health system goals and functions.

4. **Commit to a long-term process**. Most low- and middle-income countries are at a nascent stage of UHC, and still must make considerable progress to meet family planning goals. Experience shows that pathways toward these goals inevitably include detours and delays. Progress takes time, and learning comes through experimentation and iteration. These examples, and experience from countries such as Thailand, where progress toward UHC is more advanced suggest that preparing for and scaling up population coverage of government-sponsored health insurance programs is a decades-long process.

5. **Be pragmatic**. Recognizing the aforementioned points, stakeholders should be pragmatic. Over the long run, it can be expected that health financing programs will expand coverage of family planning and other services, but there will always be gaps in population coverage, service coverage, and financial protection. Insurance in particular should be viewed as part of the solution, but not a total solution. Other options, such as publicly funded services, vouchers, and savings mechanisms, will remain relevant to complement core financing initiatives.

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