

HEALTH FINANCING AND FAMILY PLANNING IN THE CONTEXT OF UNIVERSAL HEALTH CARE: CONNECTING THE DISCOURSE

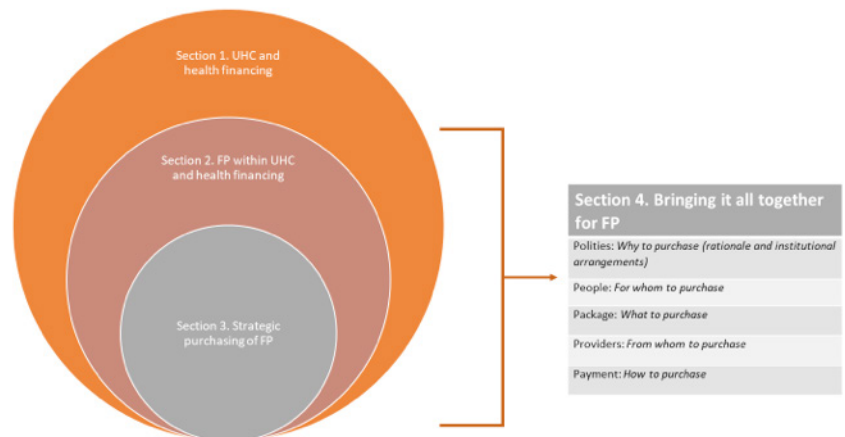
INTRODUCTION

Financing is a major challenge and concern for the future of family planning (FP) programs. As countries commit to increasing access to and quality of FP services and to universal health care (UHC), it is crucial that UHC schemes include FP and other reproductive health (RH) services. Strategic purchasing of quality FP services from public and private - including for profit and not-for-profit - healthcare providers could accelerate progress toward UHC.

It is increasingly recognized that the FP2020 goals will not be met without adequate attention to quality; and that a sustained focus on quality of care requires financing at the policy and program levels. While the importance of financing is recognized in relation to quality, the 'how' of financing FP within the context of UHC is not well understood.

This brief targets the 'bridge' constituency that is coalescing between the health financing and FP communities of practice around a shared interest in making access to health services universal. With this brief, we aim to:

- Document trends in UHC and health financing, drawing out implications for policy makers and programmers
- Identify opportunities for the FP community of practice to advocate for the inclusion of quality FP services within UHC and health financing discussions



METHODOLOGY AND OUTLINE

This technical brief drew on selected published and grey literature on health financing, FP and UHC. The technical brief is divided into four sections:

- Section one outlines salient features of health financing and UHC as well as related trends
- Section two outlines health financing for FP, current emphasis of financing efforts and the evidence base
- Section three outlines strategic purchasing and FP and its relationship with quality FP services
- Section four proposes an organizing framework for strategic purchasing for FP, outlining purchasing elements and FP considerations

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SECTION 1. HEALTH FINANCING AND UHC - SALIENT FEATURES

Health systems financing has specific functions and objectives. Financing functions are threefold – revenue generation, risk pooling and strategic purchasing (WHO, 2010). Health financing functions are intended to achieve specific objectives – generate sufficient and sustainable financing, improve the efficiency and quality of health services, and expand access to high quality services in a client-centered and responsive manner (WHO, 2016). Health financing functions and objectives are inter-related; success or failure in one has implications for ‘effective coverage’, which is the probability that someone who needs an intervention will get it and have their health improved as a result (Sparks et al, 2016).

UHC is the articulation of health financing aims, as expressed in national health strategies. UHC seeks to ensure that all citizens should receive the health services that they need without financial hardship, in recognition of the intrinsic value of health and basic human rights to self-determination, dignity, and equality. Progress toward UHC is measured by the coverage of key services and financial protection. While there is no single authoritative formulation of UHC (Ooms et al, 2014), in many countries, UHC includes national health insurance (and is often taken as shorthand for this) and entitlement schemes, such as free maternal and child health services (Maeda et al, 2014). These may be in addition to public financing of service provision through budget line-items and other forms of health service purchasing.

The drive for UHC has been accompanied by other trends in donor assistance, health financing, and health systems organisation. These trends are not smooth or necessarily linear and include the following:

- **Increased focus on domestic financing.** There is increasing emphasis on domestic financing, particularly as countries transition from low- to middle-income country (LMIC) status. Despite this emphasis, many sub-Saharan African countries spend less than 15% of their government budget on health (the Abuja Declaration target), and in many cases, these proportions are either stagnating or declining over time. Furthermore, as countries graduate from low- to middle-income, greater reliance on domestic financing does not necessarily translate into increased ‘funding for health’ and may be accompanied by widening inequities between the rich and poor (Xu et al, 2011). Out-of-pocket (OOP) expenditure has continued to feature as part of domestic financing and comprises over 40% of average total health expenditure in low-income countries (WHO, 2017). Gendered inequities in service access and the disproportionate barrier that OOP spending creates for women and adolescent girls is rarely recognised or analyzed as part of domestic financing (Witter et al, 2017).
- **Stagnation in development assistance for health (DAH).** Greater reliance on domestic financing has been prompted by stagnation of donor funding. Since 2010, stagnation has characterized DAH across all health focus areas. Past trends and associations suggest that this stagnation might be the new reality, rather than just a temporary anomaly (Dieleman et al, 2016). There is recognition that while DAH remains an important source of health financing in many LMIC, it must contribute to domestic resource mobilization rather than crowd it out (Evans and Pablos-Méndez, 2016). This has prompted some donors, such as USAID, to focus on how to responsibly transition financing and support country health systems on a trajectory toward full domestic financing (USAID, 2018).
- **Emphasis on efficiency measures.** Given the limitations of domestic financing and a context of stagnating DAH, there has been greater attention to efficiency in service provision. These efforts include allocation of resources toward services and inputs that generate better results at lower cost, pooling of funds, increasing transparency and accountability, strategic purchasing, and strengthening managerial capacities at both government and facility level (World Bank, 2017). Strategic purchasing is viewed as a means of improving quality and efficiency. However, poor targeting, inadequate use of evidence, and fragmented financing may continue to reduce the efficiency of existing investments (Lie et al, 2015).
- **Quality of care.** The financing and quality of care agendas share the same objective of maximizing the benefit derived from available resources and ensuring public health impact. However, these agendas may work at cross purposes as poor-quality services generate additional costs, through the underuse, overuse, and misuse of interventions and services, while financing arrangements may impede improvements in care (McLoughlin and Leatherman, 2003). There is evidence that financing arrangements strongly influence how institutional providers (hospitals and health systems) and individual healthcare workers provide health services (McLoughlin and Leatherman, 2003).
- **Integrated service delivery and primary health care.** There have been efforts to move away from vertical, single health service focused programs, to integrated health services across the life cycle, using primary health care (PHC) as the organizing framework. However, the content of PHC, both in terms of which interventions are included and which are priorities for universal access—has shifted over time (Lawn et al, 2008) and may present as competing discourses. For example, the economic emphasis of UHC on domestic financing have conflated it with insurance, may make it vulnerable to political and financial pressure and privilege clinical over

public health interventions (Hill, 2018; Schmidt et al, 2015). Additionally, less powerful groups, such as poor women, who have higher health needs and lower financing capabilities than men, may not be prioritized (Witter et al, 2017).

Health financing and service organisation trends have implications for FP. In many LMICs, efforts to increase FP financing operate in parallel with the development of UHC schemes and essential benefits packages (Mazzilli et al, 2016; Appleford and Camara, 2018). Given this, as countries reorganize their health financing functions, there is a risk that they insufficiently cover vulnerable populations, such as poor women and adolescent girls and boys, or fail to include priority services such as FP. This puts FP at risk of being left out of benefits packages and related UHC schemes.

SECTION 2. HEALTH FINANCING AND FAMILY PLANNING

FP financing comes from a range of sources, including international donors, national governments, NGOs and clients - the latter, in the form of OOP expenditure. FP has enjoyed 'special attention' through efforts such as FP2020 and the World Bank's Global Financing Facility (GFF), which supports governments to address a broad spectrum of intervention on the reproductive, maternal, neonatal, child and adolescent health (RMNCAH) continuum as part of the Global Strategy for Women's, Children's and Adolescents' Health. Other dedicated sources of FP financing are limited, due to a contraction of DAH in general as well as shifts in the political landscape that have created an uncertain funding environment for FP (e.g. the Mexico City Policy, and shifting donor priorities, notably USAID). Financing through client OOP expenditure is also a significant contributor to FP financing. It is estimated that OOP comprises nearly half (49%) of the costs of reproductive, maternal, neonatal, and children's health (Lie et al, 2015) and will account for most of the financing for FP over the next three years (RHSC, 2018). This form of financing may not be recognised as a barrier to access as it may not be viewed as catastrophic or a financial hardship for women and girls. As a result, it may also not be prioritized by the FP community, given other supply-side and demand-side barriers (Lie et al, 2015).

While the FP community of practice recognises the importance of sustainable financing, including domestic financing, commodities have dominated the discussion and policy priorities. This is an important piece of health financing for FP, given predicted funding gaps for commodities (RHSC, 2018). It is also the most visible as *'tracking of domestic financing is easiest for commodities since this usually entails a budget line item.'* (FP2020, 2018). As a result, there are several agencies and technical working groups focused on the establishment - and replenishment

- of budget lines for FP commodities. There has also been emphasis placed on a Total Market Approach (TMA), to increase access to priority health products, such as FP commodities, in a sustainable manner (K4Health, 2018). This approach seeks to direct subsidies towards those most in need while allowing the commercial sector to cater for those willing to pay for FP commodities and services.

Beyond FP commodities, expenditure tracking tends to focus on vertical FP financing or is reliant upon efforts to disentangle FP service elements from government RH accounts. This approach is employed by FP2020, through its single financing indicator that tracks progress on annual expenditure on FP from government domestic budgets (FP2020a, 2018). Tracking is to be aided by national FP costed implementation plans (CIPs), *'multi-year actionable roadmaps designed to help governments achieve their family planning goals.'* (FP2020a, 2018). These tend to be standalone documents, not integrated into broader health planning tools, program requirements, or government budgets. Some of these have been produced at a sub-national level given decentralization of health services, which may further compound FP expenditure tracking.

The vertical framing of FP financing tends to position FP as in competition with other essential health services. This often does not win sympathy with health financing counterparts and runs counter to health systems objectives, such as improved efficiency and service integration. In some countries, vertical FP financing is reflective of historical policies on population programs. In Bangladesh, for example, a separate directorate for FP and an independent Division of Population Control and FP was established in the Ministry of Health and Family Welfare (MoHFW) in 1975 and has retained separate financing and structures at national and sub-national levels (Bangladesh MoHFW, 2018). While vertical structures may not exist in other contexts, there remains some uneasiness with integration, as FP may 'get lost' in RMNCAH programs or forgotten altogether. For example, Marie Stopes International health financing assessments from West Africa have highlighted that contraception has frequently remained a fee-payable service in private and public facilities despite growing exemption schemes for maternal and child health (Mazzilli et al, 2016).

The FP community may also reinforce a siloed approach to quality and rights rather than employ a broader UHC frame of reference. The rights-based FP agenda and efforts to measure this are reflective of this approach. While there tends to be emphasis on rights at the point of service delivery (e.g. three FP2020 indicators address this), the conditions for rights-based FP are better addressed within and outside the health sector at political, institutional and communal levels, including work to address women's and adolescents' agency - supported through efforts to address gender equality (Ferguson and Desai, 2018). While rights

are observed in provider-client interactions and can be measured to a degree, they do not start with these interactions. Rights-based FP is implied based on observable conditions in which clients seek services, providers operate, or policy signals that enable or acknowledge human rights in FP. Signal strength, such as commitment to UHC or adequate and predictable financing, can have a powerful but indirect effect on FP service delivery. Applying a systematic rights framework to the design, implementation, and evaluation of health financing initiatives, including but not exclusively quality measures could strengthen FP services and help to move beyond the siloed approach to quality and rights (Cole et al, 2018; Boydell et al, 2018).

The lack of ‘common language’ has been recognised by the FP community of practice as an obstacle to the effective inclusion of FP within health financing and UHC.

This, at times, has been underpinned by conflicting or poorly communicated objectives but may also reflect a lack of capacity and tools to facilitate such engagement (Abt Associates, 2016). Some organisations have responded by increasing the use of market and systems-based analysis while others have developed outward facing platforms to deepen engagement on this subject (Abt Associates, 2016). These have been positioned as building health financing for FP ‘literacy’ but may still promote FP-specific language such as TMA.

There have been some recent efforts to analyse FP that explore broader financing mechanisms.

- This has included **systematic reviews of specific financing models (and their effective inclusion of FP)**, such as community financing and community-based health insurance (Karra et al, 2016), conditional and unconditional cash transfers (Khan et al, 2016), introducing, removing, or changing OOP or user fees (Korachais et al, 2016), results-based financing (Blacklock et al, 2016), performance-based incentives (Bellows et al, 2014), and social protection programs that provide a voucher subsidy (Bellows et al, 2016). A summary of the systematic reviews concluded that there is *‘limited scientific evidence on the effectiveness of the various financing mechanisms for contraception’* and that more robust studies are required (Lissner and Ali, 2016). This was evidenced by the lack of quality and methodological rigor in the 17,000 papers identified through the systematic reviews, with only 702 selected for full text review and only 38 meeting inclusion standards, or 0.2% of all papers.
- Other studies have focused on the **inclusion of FP within UHC oriented schemes in ‘transition’ health financing contexts**. For example, a study conducted by Fagen et al (2017) examined FP within social health insurance schemes in nine Latin America and Caribbean (LAC) countries and found that FP services have been

relatively well-integrated into UHC-oriented schemes in these contexts; that enrollment in government supported insurance schemes (rather than reliance on free provision through public health facilities) was associated with improved access to and uptake of modern FP methods; and, among the poorest quintile of women, insured women had a modern contraceptive prevalence rate 16.5 percentage points higher than those that were uninsured.

- More recently, a seven-country study (Ross et al, 2018) concluded that **despite the formal inclusion of FP services in national benefits packages** examined, actual integration of these services has faced challenges where issues such as unauthorized fees, lack of capacity, and limited political will, have limited the availability of FP services in practice. The study concluded that payment mechanisms need to be evaluated to assess incentivization of FP services through insurance while reliance on public facilities as sole affiliated providers for many insurance schemes may limit utilization due to low client confidence and the perception of higher quality in the private sector. In many of the analyzed countries, client confidence in the public sector is low and people may prefer to pay for services from private providers who offer, or are perceived as offering, higher-quality services.

These works and other efforts have attempted to make the ‘special case’ for FP within health financing and UHC schemes. These considerations include the range of commodities and competencies required to deliver high quality contraceptive services. These span methods that are self-administered to surgical procedures, making FP unique amongst primary health and preventative services. This range is also reflective of cadres and service levels in which FP is delivered, from community-based to higher levels of care. The political and stigmatized nature of FP and other sexual and reproductive health (SRH) services is also unique amongst PHC services. These emanate from within the health system as well as the wider socio-ecology and may include the FP community itself. For example, concerns related to coercion and choice may influence how the FP community approaches financing, in the belief that this should promote all methods equally and not single out any specific method(s) for attention. LARCs for example may require differential payment mechanisms, given the additional counseling, clinical competency and consumables required for the delivery of these services. A best practice guidance advises *‘don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior and should be avoided’* (Eichler et al, 2018) suggesting that differential payment may be supported, if this is in line with other services.

SECTION 3. FP AND STRATEGIC PURCHASING

FP financing studies, such as those summarized in the previous section, reflect the combinations of input and output-based financing that exist for FP. Some of these are integrated with other PHC services while others may be FP specific mechanisms. While these tend to be studied in isolation, in practice, they operate concurrently, if not coherently. Sources of FP purchasing may include:

- Contraceptive commodity procurement through a centralized government body using domestic and/or donor financing.
- Purchasing of healthcare services, including FP, from public health facilities through line-item budgets. This is often referred to as passive purchasing as national governments may allocate budgets based largely on funding received the previous year.
- Purchasing of health care services, including FP, from public and private health facilities through national health insurance on behalf of registered members or entitlement schemes, such as free maternity care. Often this form of purchasing is referred to as strategic, or more active purchasing, as it is based on some form of output, such as the number of deliveries attended or other health-related outcomes.
- Results-based financing (RBF) often entails financing from donors (such as the World Bank and the GFF), channeled through the Ministry of Finance to purchase services mainly from public health facilities, but may also include the private sector. In these schemes, FP is generally included as one of several RMNCAH priority services. Reimbursements are based on results in the form of incentives for reported outputs and quality indicators. RBF relies upon other inputs such as commodities, staff and infrastructure.

The array of FP financing points serves to illustrate that a narrow focus on commodities or line item budgets may miss other potential sources of FP purchasing. These may be more important over time, particularly if these are positioned as the main vehicles for UHC, as in the case of national health insurance in many contexts. Lessons emerging from Mexico and Thailand suggest that progress towards UHC in terms of developing effective financing mechanisms needs to be accompanied by attention to services which predominately affect women, such as SRH, and efforts to tackle the underlying political and social determinants that undermine access for vulnerable and marginalized groups, such as poor and marginalised women and adolescents (Witter et al, 2017). Where FP and other SRH services have been effectively included in national health insurance

schemes, this has been associated with improved access to and uptake of modern FP methods, as demonstrated in the LAC region (Fagan et al, 2017).

Ideally, more ‘active’ strategic purchasing for FP and other PHC services, drawing from a range of mechanisms, should be implemented and efforts taken to ensure that these operate coherently. This is the premise of strategic purchasing, defined as the ‘*continuous search for the best ways to maximise health system performance by deciding which interventions should be purchased, how, and from whom*’ (RESYST, 2014). The ‘how’ or mechanisms through which payments for specific services are made can be an important determinant of whether and how well services are provided (McLoughlin and Leatherman, 2003). In the case of FP, research shows that contraceptive discontinuation decreases, and contraceptive use increases with improved quality of care (Jain et al, 2017; Jain and Winfrey, 2017). ‘Who’ these payments are made to equally matters. In the case of the public sector, payment may not make its way to the health facilities delivering the services, further constraining whether and how well services are provided. The private sector may also be excluded. Considerations such as these are critical to FP given that contraceptive discontinuation accounted for about 38% of women with unmet need and accounted for about 35% of unintended pregnancies (Jain et al, 2017; Jain and Winfrey, 2017).

SECTION 4. FP AND FINANCING - BRINGING IT ALL TOGETHER

There are well known reasons for investing in FP. FP saves money, saves lives and generates broader societal benefits (Singh et al, 2009). While known to the FP community, these may not be apparent to health financing audiences. Therefore, how FP investment is approached and articulated by the FP community needs to resonate with broader UHC and health financing objectives. These are contextually defined, underpinned by a country’s UHC plans and schemes. Not engaging with this wider frame of reference reinforces a siloed approach to FP financing that may work against FP2020 objectives of increasing domestic financing in the long run. It may further position FP as in competition to other PHC services and health systems objectives, such as service integration.

How FP is included in UHC and health financing matters. Adequate financing has implications for universality and equity. This is a matter of rights, given the differential health risks and needs that women face, including unwanted pregnancy. How FP services are compensated under UHC also matters and should balance incentives for efficiency with incentives for appropriate provision using the rights-based approach to user-centered care so that risks of sub-optimal

TABLE 1. Strategic purchasing and FP

Purchasing domains	Purchasing elements	FP considerations
Polities: <i>Why to purchase (rationale and institutional arrangements)</i>	<ul style="list-style-type: none"> Political commitment Institutional arrangements Purchaser alignment (across mechanisms) Monitoring and accountability Performance management 	<ul style="list-style-type: none"> Societal benefits (FP rights, gender equality) Economic benefits (demographic dividend) Normative environment and ability to realise rights for FP Stewardship and ownership (e.g. government and donors, central and decentralized) Fragmentation and adequacy of financing (horizontal and vertical coherence)
People: <i>For whom to purchase</i>	<ul style="list-style-type: none"> Defined target clientele Clientele awareness Community and society engagement 	<ul style="list-style-type: none"> Unmet need Equity (e.g. poor women and men, adolescents) Client continued use (through method choice) Financial barriers/out-of-pocket expenditure
Package: <i>What to purchase</i>	<ul style="list-style-type: none"> Defined benefit objectives Defined benefit package 	<ul style="list-style-type: none"> Broad method mix to improve choice, enable switching, and reduce discontinuation FP integration into RMNCAH continuum/packages
Provider: <i>From whom to purchase</i>	<ul style="list-style-type: none"> Contracting Accreditation Integration (of public and private providers) 	<ul style="list-style-type: none"> Physical access/choice of outlet Minimum quality standards Integration of the private sector Client realization of FP rights
Payment: <i>How to purchase</i>	<ul style="list-style-type: none"> Payment rates Payment methods Provider autonomy Claims processing Quality assurance (data and clinical) 	<ul style="list-style-type: none"> Likelihood of being offered choice of FP method (e.g. provider behaviour) Efficiency and quality Regulatory and public financial management

outcomes are mitigated. This suggests that as UHC benefits packages are designed, there is need for the FP community to advocate for more than simple ‘FP inclusion’; the four ‘Ps’ - package, people, provider and payment - matter (Mazzilli et al, 2016). Their alignment seeks to reduce OOP barriers to FP services, improve quality of services with lower discontinuation rates, and reach all women who have an unmet need for FP. Common language would facilitate greater alignment between FP, health financing and purchasing objectives. An organizing framework for common language is proposed in Table 1. This uses a 5P framework - package, provider, people, payment and polities - the rationale and institutional arrangements that frame FP service prioritization.

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