

## Achieving Universal Access to Family Planning Services



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The private sector has an unprecedented opportunity to support governments, program implementers, and donors in achieving universal health coverage, including access to family planning services. This brief provides financial pathways to achieve these goals.

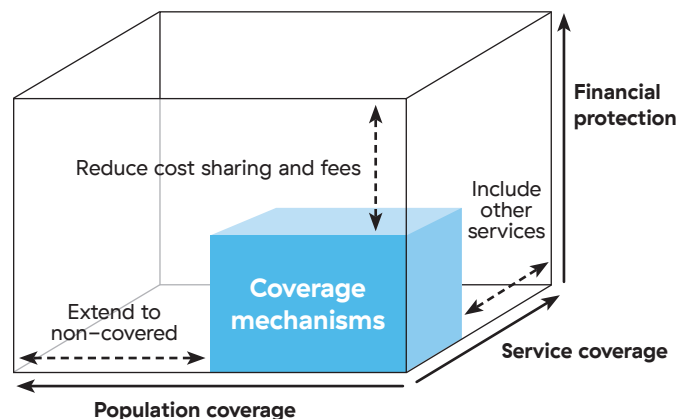
Health, including family planning, is inextricably linked to economic growth and equality—particularly for women, girls, and vulnerable groups such as the poor (Naik et al., 2014). Universal health coverage (UHC) is grounded in the principle that health is a human right.

UHC is an aspiration rather than an intervention or a strategy. It means that people can access health care when they need it, without financial hardship. The World Health Organization represents UHC as a three-dimensional cube (Figure 1).

Each dimension of the cube has relevance to family planning:

- 1. Population coverage:** Addresses who is covered, and whether coverage extends equally to all— including underserved groups and youth.
- 2. Service coverage:** Addresses what services are covered, including family planning services.
- 3. Financial protection:** Addresses what people pay out of pocket, to what extent ability to pay restricts people from getting needed health care—including preventive and outpatient care that includes family planning—and how often health events cause financial hardship.

Figure 1. Dimensions of universal health coverage



Source: Pereira Leite, 2015. Adapted from the World Health Organization.

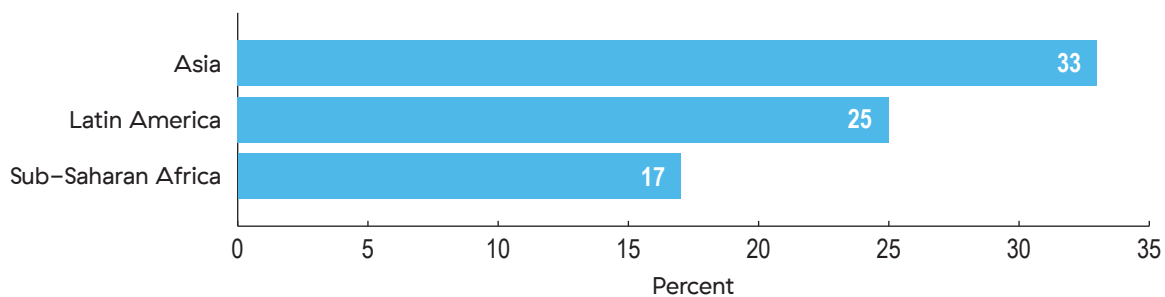
Although this brief focuses on financing mechanisms, UHC requires other substantial inputs, including sustained political will, the infrastructure and capacity to deliver care, and appropriate policies. In theory, UHC can be achieved when all three dimensions are implemented with acceptable quality. In a real-world setting, health care services are always rationed due to financial and other constraints such as an inadequate number of trained health care providers or insufficient supplies.

Several significant milestones have been reached in the pursuit of UHC. The United Nations adopted 17 Sustainable Development Goals (SDGs) in 2015 (United Nations, 2015). Goal 3 concerns health and well-being, and includes a target for UHC. Furthermore, UHC is linked to achieving other SDGs, including those for family planning, maternal and child health, gender equality, and poverty reduction. In addition, the World Health Organization and the World Bank published the first global monitoring report for UHC in 2015. Citing findings on service coverage and financial protection, the report makes the case that UHC underpins better health, and promotes equity and the end of extreme poverty. Moreover, UHC is a cost-effective development intervention, yielding positive returns on investment to public health and economic development (Naik et al., 2014).

## Approaches

Private health workers already provide substantial amounts of health care under UHC programs (Lagomarsino et al., 2012; Campbell et al., 2015). Over the past 20 years, the rate that individuals use private providers for family planning services has remained generally consistent at nearly 40 percent across Asia, Latin America, and sub-Saharan Africa. While the use of private providers is highest among wealthier women, women in the lowest economic quintile obtain 17 to 33 percent of their family planning services this way (Ugaz et al., 2015) (Figure 2). Family planning methods chosen by users of private providers, most of who must pay out of pocket, are skewed toward more affordable and more widely available short-acting methods. It is not surprising that increases in contraceptive rates have been driven by these methods.

Figure 2. Use of private providers for family planning among women in lowest-income quintile (%)



Source: Ugaz et al., 2015

Governments and donors use a range of approaches to pursue UHC, and the degree to which they engage private providers varies. One approach is for a country to directly provide health care, financed through tax payments. Most but not necessarily all hospitals and clinics would be owned and managed by the government, but private providers may also deliver services financed under these predominantly public models. Cuba, Malaysia, and the United Kingdom use a UHC approach based on a single-payer public provision model.

Other approaches to pursue UHC may feature private providers more prominently. These involve governments purchasing health care or enabling citizens to purchase health care through insurance, vouchers, or direct service agreements:

- **Insurance:** Government-sponsored or “social” insurance schemes are an increasingly common component of UHC programs. Countries with established insurance programs that anchor UHC efforts include Chile, Germany, the Netherlands, Rwanda, and South Korea. Other countries such as Ethiopia, Indonesia, and Vietnam are planning to introduce or scale up insurance programs.
- **Vouchers:** A number of governments, for example those of Uganda and Nigeria, purchase health care from private providers by distributing vouchers, usually to vulnerable groups such as the poor or pregnant women. A client can obtain family planning, maternal health care, or other services at little or no cost after she “pays” with a voucher.
- **Direct service agreements:** Governments may choose to purchase services from private providers under direct service agreements. This “buy versus build” approach may be a faster, more efficient way to expand access to care and to complement the care that is available at government facilities. For example, from 2005 to 2011, Marie Stopes Tanzania and multiple local government authorities in Tanzania formed a partnership, with support from the Canadian International Development Agency to expand access to maternal and child health, and HIV and AIDS services.

## Family Planning

Access to family planning services contributes directly and efficiently to achieving UHC and other components of the SDGs. Analysis of 74 countries accounting for 95 percent of maternal and child deaths found that scaling up family planning and preventing unintended pregnancies would avert more than half of preventable child deaths between 2013 and 2035. Other research reviewed data from 172 countries and estimated that family planning prevented 272,000 maternal deaths in a single year (USAID, 2014). From a financial perspective, governments can save up to \$6 for each dollar invested in family planning, freeing limited resources for other health priorities (Hofmann and Cooke, 2014). Every dollar spent on contraceptive services and preventing unintended pregnancies saves \$1.40 on costs associated with maternal and newborn health (Singh and Darroch, 2012).

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Chloé Revuz



However, global momentum toward UHC does not always translate into increased family planning service coverage, financial protection, or population coverage. Unmet need for family planning remains high, especially among the poor, for a number of reasons:

1. **Availability:** In most settings, free or low-cost family planning services are, in theory, covered and available to all at public facilities. In reality, these services may be unavailable when the client seeks care due to circumstances such as long wait times; commodity stock-outs; lack of trained providers who can provide a full range of services, including long-acting reversible contraceptives and permanent methods; demands from providers to make under-the-table payments; unhygienic conditions; or insensitive treatment.
2. **Fiscal space:** In many developing countries, family planning and other preventive services remain substantially funded by donors. Thus, governments that face difficult decisions about which services to cover with limited funds may make family planning a low priority, under the assumption that other sources will fund these services.
3. **Unaffordability:** Governments inevitably face trade-offs across the three dimensions of UHC mentioned in the figure on page 1. Many prioritize financial protection over service coverage and population coverage—leading to diminished coverage of family planning services, especially lower-cost, short-acting methods. In particular, when government-sponsored insurance makes financial protection a priority, service coverage often focuses on inpatient events likely to be financially catastrophic. This approach conforms to conventional insurance practices, but benefit plans that exclude preventive care and outpatient services do little to reduce financial barriers to accessing family planning services, since most of these services are obtained in outpatient settings. Paradoxically, benefit plans that cover only inpatient care may not achieve the intended financial protection—the higher frequency of outpatient expenses, including those for family planning services and supplies, is equally or more likely to cause household impoverishment (Pott and Holtz, 2013).
4. **Administrative ease of inpatient plans:** Insurance-based UHC initiatives may opt for inpatient benefit plans (and exclude benefits for family planning) because these plans generate far fewer claims, making them cheaper to administer and less subject to fraud and overuse.

With the adoption of the SDGs and the expansion of efforts to achieve universal access to family planning and other health services come greater recognition of the role that the private sector can, and should, play. The process of coordinating the contributions of the public and private sectors, also referred to as a total market approach, considers elements such as the use of subsidies, incentives for the private sector, and enabling policies to achieve public health goals (Armand and Mitchell, 2014). Opportunities—and some associated risks—are on the rise for private family planning providers, notably:

- **Growing demand for family planning services:** UHC emphasizes extending coverage equitably to all, regardless of ability to pay. As UHC programs succeed in reaching the poor, they will extend coverage to individuals with the highest unmet need for family planning (Naik et al., 2014), creating an increase in demand for services, and growing opportunities for providers to serve these new clients. FP20/20 has an ambitious goal to reach 120 million new family planning users in 69 of the world’s poorest countries by 2020. This will require equipping all types of private providers with the necessary knowledge, skills, and commodities to effectively counsel and provide women, youth, and couples with a wide range of methods. This undertaking will take tremendous coordination and support—and a willing private sector.
- **New revenue streams:** Another emerging opportunity is for private family planning providers to increase revenues from governments and other payers, and become less reliant on out-of-pocket payments. The threat is that private providers will fail to adapt their operations and management practices and will not be successful in participating in UHC programs. Additionally, payments from governments may be unreliable or delayed, and must be monitored closely.
- **Organization and consolidation:** There is strength in numbers; growth in purchasing private family planning services by government sponsors will encourage organized groups such as social franchises, networks, and associations to expand in number, size, and role. These groups are able to negotiate with increased bargaining power, drive economies of scale, share knowledge, pool capital, and reduce administrative costs. Their members are able to internally share expertise in advocacy, contracting, marketing, purchasing,

and quality assurance, which may improve their sustainability. Additionally, organized provider groups offer purchasers one point of contact for delivering multiple services. Without better organization, and an accompanying rise in quality and consistency, solo practitioners could fall through the cracks.



A. S. A. Masud

*One-third of women in the lowest economic quintile in Asia obtain their family planning services from a private provider.*

Family planning providers can take advantage of these opportunities and avoid associated risks through horizontal consolidation. For example, a group of solo providers may organize under an association or merge into a common legal entity. Since the 1990s, more than 80 social franchise networks in 43 countries have succeeded in organizing thousands of providers (Viswanathan and Avanceña, 2015). In general, social franchises strive to reach underserved, poor, and vulnerable populations—consistent with UHC objectives—through voucher programs or other efforts. They offer franchisees opportunities to improve the quality and viability of their operations through branding, bulk purchasing, quality improvement programs, and training. This improves the ability of franchisees to partner with government or private health care purchasers directly or through voucher or insurance programs. In some cases, franchisees also receive support related to accreditation with government-sponsored programs.

#### Linking private midwives to the Philippines National Health Insurance Scheme

In the Philippines, the Well-Family Midwife Clinics and BlueStar Pilipinas clinical social franchise programs link private sector midwives to the National Health Insurance Scheme managed by PhilHealth. Both programs provide operational, financial, and technical assistance to support franchisees in becoming accredited to provide maternity and newborn services covered by the national scheme. Well-Family Midwife Clinics was instrumental in influencing PhilHealth’s payment rate and accreditation standards, while BlueStar Pilipinas ensured that franchisees can access essential capital and supplies while linking them to referral physicians to meet minimum infrastructure and accreditation requirements. Both programs have supported franchisee revenue generation, built a reputation of providing quality care, reduced out-of-pocket payments, and expanded the range of available products and services. Despite these gains, both networks rely on donor funding to operate and have yet to achieve financial sustainability.

*Source: Viswanathan and Avanceña, 2015*

Growing horizontal consolidation is evident in another example: in 2013, six social franchise networks (Population Services Kenya, Marie Stopes Kenya, Gold Star Kenya, CFW Clinics, Kisumu Medical and Education Trust, and Family Health Options Kenya) joined forces to organize more than 1,000 private providers throughout Kenya in a “network of networks,” called the Association of Social Franchising for Health (ASFH). The association aims to share knowledge, promote quality improvement, and support members to scale up more efficient operations. It advocates for including ASFH members in Kenya’s National Hospital Insurance Fund to increase access to revenue streams from government-sponsored programs and to family planning services for low-income Kenyans. ASFH is also evaluating how it can support future expansion of family planning benefits under the National Hospital Insurance Fund.

Vertical integration is also possible, whereby a network assembles a broad range of skills and capacity, so that clients can receive (and governments or other entities can purchase) a spectrum of services within the network with consistent quality standards and greater convenience. For example, Tunza, a social franchise operated by Population Services Kenya,

builds the capacity of its franchisees to offer a set of primary and preventive care services that complement core family planning services, such as HIV and AIDS testing and screening for cervical cancer. Some Tunza franchisees also provide maternal and child health services, including deliveries. This necessitates more investment in risk management and protocols for referrals developed and overseen by the network, given the higher risk of adverse effects including infection, disability, or death.

#### A network of networks: Kenya's Association of Social Franchising for Health

- Founded in 2013 by six social franchises in Kenya: Population Services Kenya, Marie Stopes Kenya, Gold Star Kenya, CFW Clinics, Kisumu Medical and Education Trust, and Family Health Options Kenya
- Aims to share knowledge, promote quality improvement, and support members to scale up more efficient operations
- Supports more than 1,000 private providers

## Looking Ahead

Difficult trade-offs between the three dimensions of UHC—population coverage, service coverage, and financial protection—will continue as governments expand efforts to achieve universal access to family planning and other health services. To be part of this debate, a more organized private health sector—capable of advocating for and creating new partnerships to finance and deliver these services—will be essential. Future partnerships might look similar to Kenya's ASFH.

Private health providers are well-positioned to reduce unmet demand for family planning and provide more services, including long-acting and permanent methods, to many more clients served by government programs that deploy direct contracts, vouchers, or insurance—but there is still much to be done. To succeed, providers will need more practitioner-based tools and guidance on topics such as contracting and payment mechanisms, and best practices to deliver quality, affordable services.

Frontrunners in organizing private providers and collaborating under public-private partnerships for UHC should share lessons learned. To enable access to affordable family planning services, more public-private partnerships are needed under expanding UHC initiatives, particularly for insurance programs.

Private family planning providers, working with their government counterparts, have an unprecedented opportunity to support the achievement of UHC and universal access to family planning by 2030, as declared under the SDGs. This will require a reduction of financial and other barriers for people to access care, mobilization of more resources for preventive and primary care, and greater engagement between government and the private sector.



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