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THE ROLE OF HEALTH INSURANCE IN FAMILY PLANNING

Health insurance
decreases financial
barriers and increases
access to health care.

**21
MILLION**

The number of unplanned
births potentially avoided
by universal access
to family planning.

Every dollar spent on
contraceptive services
to prevent unintended
pregnancies saves
\$1.40 in maternal
and newborn costs.

More than 200 million women in developing countries who want to avoid or delay pregnancy are not using family planning.¹ These women have an unmet need that can result in unintended pregnancies, unsafe abortions, poor health, and strains on families and economies. Improving access to voluntary family planning could mitigate these challenges and lead to a host of other benefits. The post-2015 focus on universal health coverage in low- and middle-income countries and growing evidence that health insurance programs can enhance access to health services offer an opportunity to help fill the gap in unmet need by including family planning in health insurance benefits packages. This policy brief discusses the benefits of family planning and how insurance programs can be designed to increase demand for and uptake of family planning services, as well as to improve their quality and equitable provision.

Why Family Planning Matters

Family planning is crucial for advancing reproductive, maternal, and child health. Universal access to family planning would reduce unintended pregnancies by two-thirds, resulting in 21 million fewer unplanned births and 26 million fewer induced abortions.² Between 1990 and 2010, family planning helped cut worldwide maternal deaths in half; it is estimated to prevent as many as one in every 11 child deaths.³ Research also shows that when women voluntarily use family planning to space their children and have the number they want at the healthiest times in life, nutrition improves across the life cycle. When birth spacing is optimal, infants are more likely to be born the right size and weight, children are less likely to be stunted, and women's bodies have sufficient time to replenish essential vitamins and nutrients.⁴

The benefits of family planning go beyond health. With smaller families, parents can invest scarce resources in the education and futures of their

children. Women with fewer children are better able to seek employment, increasing household income and savings. In the long term, expanded use of family planning can lead to a host of other benefits, including poverty reduction and both human and economic development for nations.⁵

Given the potential of family planning for far-reaching health, development, and economic gains, governments and their development partners are looking for new ways to increase the uptake and quality of family planning services.

The Role of Health Insurance

Universal health coverage—ensuring “that all people obtain the health services they need without suffering financial hardship when paying for them”—is a global health priority in the post-2015 development agenda.⁶ The director general of the World Health Organization has declared universal health coverage “the single most powerful concept that public health has to offer.”⁷ And several countries—including India, Ghana, Indonesia, the Philippines, Rwanda, Vietnam, Kenya, Mali, and Nigeria, among others—have demonstrated a strong commitment to universal health coverage, with many others slated to follow suit.⁸ Given this momentum, it is time to think critically about how the goals of universal health coverage can be advanced through health insurance to ensure that women worldwide are empowered to choose the size, timing, and spacing of their families.

Health insurance pays for all or part of medical or surgical expenses for the insured, mitigating out-of-pocket payments as a barrier to health care and providing financial risk protection against catastrophic health expenditures. Different types of insurance models have varying funding sources and provider payment mechanisms (see table, page 2). Many countries have some form of insurance program in place and coverage has

Models of Health Insurance

TYPE OF INSURANCE	FINANCING SOURCE	MANAGEMENT	COUNTRIES
National Health Insurance	General taxes	Public sector	Canada, Costa Rica, France, United Kingdom
Social Health Insurance	Payroll taxes from employers and employees	Social security agency, health fund, sickness fund(s)	Colombia, Germany, Japan, South Korea, United States (Medicare)
Private Voluntary Insurance—Commercial	Premium payments from individuals or employers/employees	Commercial insurance company, for-profit or not-for-profit	South Africa, United States
Community-based Health Insurance	Premium payments from individuals and/or community	Community or association	China, India, Philippines, Rwanda, Senegal

Source: Adapted from Hong Wang et al., *Health Insurance Handbook – How To Make It Work* (Washington, DC: World Bank, 2012).

increased considerably. In 2003-2004, about 55 million people in India had access to health insurance, and by 2010, this figure had risen to over 300 million covering 25 percent of the population.⁹ In Rwanda, prior to a community-based health insurance pilot in 1999, no health insurance program was in place; by 2010, coverage had exceeded 90 percent.¹⁰

When developing insurance programs, governments and health insurance providers must carefully decide on a benefits package that clearly describes the types of services covered, along with levels of coverage and any applicable exclusions and/or limits on services. Since lack of access and inability to pay are important reasons women do not use family planning, inclusion of family planning services in health insurance programs could increase uptake.¹¹ The Commission on Macroeconomics and Health has suggested criteria for choosing essential health interventions. Family planning is a strong match to the key criteria because it is a technically effective intervention, can be delivered successfully, addresses health issues that impose a heavy burden on society, and has benefits beyond the intervention itself.¹²

It is well established that family planning results in benefits beyond reducing unmet need and lowering fertility—benefits such as fewer maternal and child deaths and complications from abortions; and improved nutrition outcomes among women, infants, and children. Given the high cost of addressing maternal and child health, these benefits can lead to considerable savings for health systems and insurance providers. For example, every dollar spent on contraceptive services to help women prevent unintended pregnancies saves \$1.40 in maternal and newborn health care costs. At this level, spending \$8 billion to address the unmet need of all women globally would result in a savings of more than \$11 billion in maternal and newborn health services.¹³ With the inclusion of family planning in insurance benefits packages, governments that offer free family planning services can also benefit from cost savings.

Health Insurance and Uptake of Health Services

Studies show that health insurance decreases financial barriers and increases access to health care generally, as in the Philippines, Rwanda, and Ghana.¹⁴ And a review of the effect of insurance on maternal health found that insurance positively influences uptake of facility-based delivery across all types of insurance schemes in a number of developing countries.¹⁵

For family planning specifically, the evidence is more limited though nonetheless promising. In the United States, which has long-term experience with various financing schemes, insurance and health care coverage plans have been shown to increase family planning uptake. An analysis by the Brookings Institution found that expanding access to publicly provided family planning services through Medicaid, a government-run program that provides health care coverage for low-income clients, significantly increased the use of contraception and reduced unintended pregnancies among low-income American women. In the states where Medicaid was expanded, the study estimates that birth rates declined by 7 percent among women ages 18 to 19, and by as much as 15 percent among 20-to-24-year-old women who were newly eligible for family planning coverage.¹⁶

In low- and middle-income countries, reproductive health vouchers with features similar to insurance have also shown positive results. A voucher program in Kenya resulted in more use of family planning services.¹⁷ And a study in Indonesia found increased use of contraceptives among females eligible for a health card program targeted to the poor.¹⁸

In a multicountry study of health insurance and family planning uptake, seven countries had varying levels of insurance and five had some coverage for family planning in their insurance package. Unmet need was high in all countries except Colombia (high insurance coverage) and Turkey

BOX 1

Health Insurance and Family Planning in Ghana

The government of Ghana is integrating coverage for family planning into the country's National Health Insurance Scheme (NHIS). NHIS is a public health insurance scheme funded through general government revenue, a national health insurance levy, social security contributions, and individual premiums. Several vulnerable groups are exempted from premium payments; health services included under the benefits package are provided to participants free of charge.

The NHIS benefits package covers 95 percent of diseases in the country. However, it initially excluded family planning services because other programs existed for family planning that were implemented by the Ghana Health Service under the Ministry of Health as well as by international partners. Despite these programs, barriers to access still exist. Although family planning services at public and some nonprofit facilities are subsidized, many women still cannot afford them. According to a recent report, most public district- or higher-level hospitals have a family planning unit to which clients are referred, but these services are limited at lower-level facilities. Clients who come to health facilities for general health conditions do not routinely receive family planning counseling or services. The report called for increased integration of family planning services into health care visits for other causes.

To address challenges to family planning access, in 2012 legislation addressing NHIS reform required inclusion of a family planning package to be determined by the Minister of Health. Under the reform, family planning education and services will be part of the package of free maternal health care provided under the NHIS. The use of family planning services is expected to increase as financial barriers fall and health care providers increasingly discuss family planning with their clients.

Sources: National Health Insurance Authority, Ministry of Health, Ghana, "National Health Insurance Scheme," accessed at www.nhis.gov.gh, on Aug. 4, 2014; Amos Laar, *Integration of Family Planning Into Other Health Services in Ghana: Midterm Report on the Performance Needs Assessment at Four Facilities in the Ashanti and Eastern Regions* (New York: Population Council, 2012); Republic of Ghana, "National Health Insurance Act, 2012 (Act 852)" (Accra, Ghana: Parliament of the Republic of Ghana, 2012); and "Women to Access Free Family Planning Services," *Graphic Online*, Dec. 2, 2013.

(medium insurance coverage), both of which included family planning services in their health insurance packages. Overall, the study showed that there was a positive relationship between insurance and family planning uptake in all countries; however, it was only conclusive in one country—Kenya.¹⁹

In Kenya, health insurance coverage is quite low (7 percent) and unmet need for family planning is high (26 percent). Insurance coverage in Kenya, which includes only surgical family planning, is primarily concentrated among populations in urban, educated, middle to upper socioeconomic groups, and is mostly employer-based or private. The study design limits causal explanations; however, the link between insurance and family planning uptake could be explained by greater availability of family planning commodities in Kenya given stronger supply chains or better perceptions of the quality of providers who participate in these health insurance programs. It may also be that those women most inclined to use family planning are also those most likely to have health insurance.²⁰

Health Insurance Can Bolster Family Planning

Although better evaluations are needed, current evidence suggests that multiple factors must be addressed to increase family planning uptake. Well-designed insurance programs offer a way to improve the quality and equitable provision of family planning services.

Expanding coverage creates more opportunities to offer family planning education and services.

Insurance coverage is often limited to those who are employed within formal institutions or who can afford private insurance. However, expanding coverage and eliminating financial barriers would increase client contact with health facilities and providers, creating more opportunities for family planning education and service provision. More frequent interactions with providers on a range of health issues may also increase clients' trust in providers and could lead to positive spillovers for uptake of family planning. One study notes that trust and rapport between clients and providers may even be a more important determinant of family planning acceptance than the number of methods available.²¹

Including family planning in the benefits package can strengthen the infrastructure for family planning services.

To participate in most insurance programs, health facilities must be accredited and must meet basic standards of staffing and other resources to deliver care. When family planning is part of the benefits package, this accreditation requirement can help ensure that an adequately trained staff and sufficient

BOX 2

Health Insurance and Family Planning in Rwanda

In recent years, Rwanda has achieved nearly 90 percent insurance coverage and has seen substantial increases in family planning uptake. Modern contraceptive prevalence rose from 6 percent in 2000 to 45 percent by 2010. And Rwanda's fertility rate of 4.6 reflects a drop by 1.5 children per woman since 2005.

Members of Rwanda's community-based health insurance system *Mutuelles de santé* pay an annual premium of about 1,000 Rwandan francs (approximately US\$1.80) per family member and a 10 percent copayment fee for all services at the health care facility. Annual premiums account for about 50 percent of the program's funding, while the remaining half is obtained from other insurance funds, charitable organizations, NGOs, development partners, and the government. Those classified as very poor are exempt from payments and their membership is subsidized through pooled funds. Members are entitled to comprehensive benefits for primary care, secondary care, and tertiary care provided through public or private nonprofit contracted facilities, including family planning, antenatal care, basic laboratory examinations, generic drugs, and hospital treatment. Health care providers are paid directly by the program, either based on fee-for-service or through a recently introduced performance-based system.

Health insurance and family planning stakeholders in Rwanda report that adding family planning into the insurance benefits package was not the primary driver of increased uptake, but they did acknowledge that it made some important contributions. For example, respondents reported that expansion of health insurance increased access to and use of health information and services generally and as a result helped change attitudes and behaviors around family planning. Increased contacts with providers through insurance opened new windows to discuss and obtain family planning methods. Further, insurance led to increased access to conventional medical care, which raised clients' level of comfort and trust in conventional versus traditional medicine. Study respondents universally noted this experience as a significant contributor to increased uptake of family planning.

The case of Rwanda shows how insurance complements other essential factors critical to ensuring high coverage and quality of family planning—factors like a strong commodity logistics system, family planning education, provider training, and regular quality monitoring.

Sources: Julianna Kohler et al., *The "Insurance Effect": Exploring Health Insurance and Family Planning Uptake in Rwanda* (Bethesda, MD: Abt Associates Inc., 2012); and Chunling Lu et al., "Towards Universal Health Coverage: An Evaluation of Rwanda *Mutuelles* in its First Eight Years," *PLOS One* 7, no. 6 (2012), accessed at www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0039282, on Oct. 15, 2014.

infrastructure are in place for the delivery of high-quality contraceptive services and information.

Including family planning in insurance packages could bolster the contraceptive supply chain. The authors of one study proposed that a reliable and consistent funding stream, through taxes or insurance premiums, may enable more frequent procurement of commodities including contraceptives.²² Moreover, because provider reimbursement depends on accurate data and health statistics, inclusion of family planning in benefits packages could strengthen family planning data at the facility level, enable more accurate forecasting to prevent stockouts, and ensure that the right quantities and types of contraceptive methods are available.

These improvements to the health care infrastructure and contraceptive supply can increase uptake of family planning as facilities become better-equipped to provide services and clients gain confidence in the quality of services provided.

Tying provider reimbursement to quality can boost family planning uptake.

The quality of reproductive health services is an important determinant of whether women adopt, continue to use, or recommend family planning methods to others.²³ Good counseling may "encourage clients to present problems at an earlier point and lead to switching [to a different family planning method] ... it may also lay the foundation for longer-term contraceptive use and greater client satisfaction."²⁴

If family planning is included in the benefits package and health insurance programs tie reimbursements to quality, providers are encouraged to present women with a full choice of methods, offer thorough counseling, and ensure client follow-up and continuity of care.²⁵ Given that concerns about side effects or perceived health risks are among the top reasons for nonuse of family planning among married women in Africa, Asia, and Latin America and the Caribbean, such improvements in the quality of counseling and services can have a positive effect on family planning uptake.²⁶ These improvements can increase trust in providers and address other key barriers such as misperceptions about the risks of pregnancy in the context of breastfeeding or infrequent sex.

Designing pro-poor insurance programs can enhance equitable distribution of family planning services.

Governments and donors increasingly recognize that providing equitable access to family planning and other reproductive health services is essential for development. Significantly reducing unmet need depends on reaching poor populations, who are generally much less likely to use family planning. In Kenya, for example, nearly twice as many poor married women (40 percent) have unmet need for family planning compared to middle-income (22 percent) and wealthy women (19 percent).²⁷

When insurance programs are designed to be pro-poor, they can reach more of those in need and ensure that services are equitably delivered.

Many experiments with insurance in low-income countries, both public and private, only reach a small proportion of the population, with the poor less likely to be covered. However, some programs enhance equity by focusing on vulnerable populations and using complementary outreach and communication strategies to provide information and services. Brazil's Family Health Program, introduced in 1994, and Mexico's *Seguro Popular* initiative, launched in 2004, aspire to universal coverage, but rather than taking the traditional approach of serving the easiest to reach, the programs were designed to increase coverage first among disadvantaged groups.²⁸ Insurance programs based on such models can improve equity in the distribution of both family planning and other health services.

Conclusion

As we move into the post-2015 development agenda with an increasing focus on universal health coverage and health insurance, it is time to engage in a critical dialogue about how to design health insurance to bridge the gap in unmet need for family planning. Although limited, the evidence does provide valuable insights that can help guide future efforts: When family planning is included in the benefits package and when insurance programs are well-designed, these synergies can improve the uptake, quality, and equitable provision of family

planning services. In particular, programs with broad coverage that tie provider reimbursement to quality of service and reach vulnerable populations offer an opportunity to reach more women with needed family planning services. Including family planning in the benefits package removes financial barriers and strengthens the infrastructure for service delivery, taking these gains to even higher levels. Over time, system-wide changes in the delivery of family planning services engendered by the careful design of health insurance programs can yield improvements in knowledge and social norms around family planning, further accelerating its acceptability and use.

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