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IS HEALTH INSURANCE COVERAGE ASSOCIATED WITH IMPROVED FAMILY PLANNING ACCESS?

A Review of Household Survey Data from Seven FP2020 Countries

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Abbreviations

CBG	case-based group
CBHI	community-based health insurance
DHS	demographic health survey
HP+	Health Policy Plus
JKN	Jaminan Kesehatan Nasional
LARC	long-acting reversible contraceptive
mCPR	modern contraceptive prevalence rate
MHIF	Mandatory Health Insurance Fund
NHIF	National Health Insurance Fund
NHIS	national health insurance scheme
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
UHC	universal health coverage
USAID	U.S. Agency for International Development

Introduction

Health financing and health system reforms aimed at universal health coverage (UHC) present an important opportunity to ensure the long-term, sustainable financing of healthcare. Many countries have implemented or expanded coverage of health insurance schemes as the primary conduit for reaching universal health coverage (Fagan et al., 2017) and evidence from developing countries suggests that health insurance coverage is associated with higher rates of healthcare utilization (Abera Abaerei, 2017; Dalinjong et al., 2017; HP+ and TNP2K, 2018; Shihab et al., 2017). In countries where publicly provided health services require user fees, are difficult to access, or are of poor quality, expansion of health insurance membership alongside a generous benefits package can reduce financial barriers to access.

Universal health coverage achievement is defined as providing all people with access to needed promotive, preventative, curative, and rehabilitative quality health services, while ensuring that people do not suffer financial hardship in paying for these services (WHO, 2017).

In recent years, integration of family planning services into broader health financing schemes—and, more specifically, health insurance schemes—has been a primary focus for the U.S. Agency for International Development (USAID) and its implementing partners. Inclusion of family planning into health insurance can provide a designated, more predictable revenue stream to finance facility-based services and can stimulate underlying demand for services. If the effects of health insurance coverage and utilization also apply to family planning services, then it can be expected that insurance coverage will lead to increased access to and use of family planning services when these services are included in health insurance benefits packages. The extent to which family planning services have been included in benefits packages of health financing schemes aimed at achieving UHC has been well documented (Abt, 2017; Avenir Health, unpublished; Fagan et al., 2017; Holtz and Sarker, 2018).

However, evidence suggests that additional factors must be considered—one recent study of nine countries in Latin America and the Caribbean found that formal inclusion of family planning services in health insurance benefits packages is not sufficient to ensure equitable improvements in the modern contraceptive prevalence rate (mCPR) across population groups. Additionally, the effect of reduced financial barriers to access is expected to be more significant for certain methods (e.g., long-acting methods with high upfront costs) and certain users (e.g., poorer users who face a more significant financial burden on health-seeking behavior). Another study notes that the payment mechanisms used by insurance schemes to reimburse providers for family planning services may incentivize or disincentivize the provision of certain methods, which emphasizes the importance of strategic purchasing to ensure unbiased choice across contraceptive methods (Mazzilli et al., 2016).

The USAID-funded Health Policy Plus (HP+) project conducted an analysis to systematically examine the association between health insurance coverage and key family planning access indicators in seven developing countries. The analysis is structured around the following questions:

1. What are the characteristics of the health insurance schemes in the sampled countries, and to what extent has family planning been incorporated into each scheme?
2. Is membership in the health insurance scheme associated with higher mCPR or differences in method mix and source, compared to non-membership?

3. Does insurance promote health equity in the family planning context (i.e., is insurance status associated with improved family planning access among the poor)?

Methodology

HP+ analyzed seven low- and lower-middle-income countries from the World Bank's Universal Health Coverage Studies Series that have made significant progress toward instituting and scaling-up UHC-oriented schemes (Giedion et al., 2013). These countries also committed to expanding access to family planning information, services, and supplies under the global FP2020 initiative. In addition, these countries (listed in Box 1) had recent nationally representative household-level data on family planning indicators and insurance coverage.

Box 1: Study Countries, Data Source, and Year

1. Ethiopia (2016 DHS)
2. Ghana (2014 DHS)
3. Indonesia (2015 Susenas)
4. Kenya (2014 DHS)
5. Kyrgyzstan (2012 DHS)
6. Nigeria (2013 DHS)
7. The Philippines (2013 DHS)

Data on insurance coverage over time and the extent to which family planning has been integrated into health insurance was collected through a desk review of literature on the countries' health systems and health financing structures. HP+ conducted statistical analysis of key family planning access indicators stratified by insurance coverage status and asset-based wealth quintiles. For six of the seven countries included in the analysis, data from the most recent Demographic and Health Survey (DHS) were used, including the asset-based wealth quintile indicators. For Indonesia, data from the 2015 national household survey (*Susenas*) were used, alongside an asset-based indicator of socioeconomic status. With each of these datasets, HP+ analyzed three family planning access indicators: mCPR, modern method mix, and most recent source of modern contraceptive method among users. Insurance coverage was self-reported in the DHS women's individual survey module or in the household module. In order to maintain sufficient sample size for statistical analyses, HP+ did not disaggregate insurance status by type of insurance (public or private) or specific scheme. All analyses were limited to women of reproductive age who were married or in union at the time of the survey (referred to as "married" in this report) and were adjusted for country-specific sample design.

Findings and Discussion

Characteristics of Health Insurance Schemes and Inclusion of Family Planning Services

This section presents background data on the health insurance schemes in each country. For each scheme, HP+ reviewed the population covered, the type of providers contracted (public or private) and how services are reimbursed, and whether family planning services are included in the benefits package.

Who is covered by the insurance scheme and how is it financed?

Of the seven countries analyzed, all but Ethiopia are currently implementing a national-level insurance scheme. Though each scheme is ostensibly designed to achieve UHC, population coverage varies significantly (see Table 1). The Philippines' PhilHealth had the highest population coverage: 91 percent as of 2016 (Chakraborty, 2013; JLN, n.d.). Kyrgyzstan's

national health insurance program is mandatory for all citizens and also has high coverage—at the end of the *Manas Talimi* health reform program in 2011, 70 percent of the population was covered (Giuffrida et al., 2013). Since then, the Mandatory Health Insurance Fund (MHIF) is continuing to consolidate under the *Den Sooluk* national health sector reform program, and coverage may be higher at this point in time. Indonesia's *Jaminan Kesehatan Nasional* (JKN) program, a national health insurance program built on the foundations of previous social health insurance schemes, covered three-quarters of the population as of early 2018 (BPJS, 2018). In Ghana and Kenya, health insurance schemes offer coverage to many citizens but are far from reaching high coverage. As of 2015, the national health insurance scheme (NHIS) in Ghana covered 40 percent of the population (AS4H, 2016). The National Health Insurance Fund (NHIF) in Kenya covered approximately 20 percent of the population in 2014 (Kazungu and Barasa, 2017). In Nigeria, the national scheme (NHIS) covers only the formal sector—a very limited share of the overall population—and may have covered just 10 percent of the population in 2015 (data to establish a firm estimate are limited) (Windmeyer, 2017c). Nigeria also has a patchwork of state-level, community-based health insurance schemes that provide varying benefits and levels of access. Comprehensive reform related to funding primary and basic secondary healthcare under the Basic Health Care Provision Fund established by the National Health Act of 2014 (including through an insurance mechanism) is in progress but has not been fully initiated as of mid-2018.

In contrast to the national insurance initiatives of the other countries, Ethiopia implements a community-based health insurance (CBHI) scheme to finance certain pre-paid primary and basic secondary health services, covering approximately 14 percent of the population in 2016 (HFG, 2015; Windmeyer, 2017a). Ethiopia is fairly advanced in its plans to roll out a social health insurance scheme, integrated with CBHI, to create a national health insurance scheme in the future.

Expanded insurance coverage may not always translate to increased access to health services for the poor, as this depends on who is covered. Many health insurance schemes, including those in the seven countries analyzed, have focused on the formal sector. Formal sector employees are more likely to be middle-class, compared to informal sector workers, and hence have greater ability to pay for health services out-of-pocket. Therefore, insurance may not necessarily be associated—or may demonstrate lower than expected association—with increased utilization of basic health services, including family planning.

What payment mechanisms are used by each insurance scheme?

With the exception of Ethiopia, all of the schemes examined use capitation as the main form of provider payment at the primary healthcare level. Capitation systems—usually based on a fixed per-person payment, with a total payment based on the number of individuals in the provider's catchment area–may incentivize providers to under-provide services or prefer lower-cost and less time-intensive services. For family planning services, this could mean that providers are incentivized to provide long-acting methods that have a lower cost per couple years of protection and require less frequent clinical visits (Sharma, 2018). Alternatively, with a fee-for-service payment mechanism, providers are incentivized to over-provide health services, as payment is based on per-service episode. For family planning, this may mean a bias toward methods bearing a higher reimbursement, such as those involving surgical intervention or frequent clinical visits. Any provider-level bias toward a specific method limits patient choice, thereby compromising a rights-based approach to family planning access (Agha and Do, 2009; Machiyama et al., 2017).

Table 1. Summary of UHC-Oriented Health Insurance Schemes

Country	Scheme Name (Year Launched)	Population Coverage	Population Segments and Financing Source	Payment Mechanism	Contracted Providers
Ethiopia	CBHI (2011)	14% (2016)	**General population:** voluntary fixed household premiums **Poor:** subsidized premiums financed by local and regional government	Fee-for-service	Mostly public; limited private sector contracting
Ghana	NHIS (2003)	40% (2015)	**Formal sector workers:** 2.5% payroll tax through Social Security and National Insurance Trust **Informal sector workers:** fixed premiums through District Health Insurance Schemes **Poor:** subsidized premiums financed by the NHI levy (value-added tax earmark)	Capitation for primary providers; fee-for-service and case-based groupings (CBGs) for hospitals	Accredited public and private facilities
Indonesia	JKN (2014)	75% (2018)	**Formal sector workers:** payroll tax split between employees and employers **Informal sector workers:** fixed premiums **Poor and near-poor:** subsidized premiums financed through general tax revenues	Mostly capitation for primary providers; CBGs for hospitals	Accredited public and private facilities
Kenya	NHIF (1966)	20% (2014)	**Formal sector workers:** payroll tax **Informal sector workers:** fixed voluntary premiums **Poor:** subsidized premiums financed through general tax revenues and external support	Fee-for-service; capitation	Public and private facilities
Kyrgyzstan	MHIF (2001)	70% (2011)	**Formal sector employees:** payroll tax **Poor:** subsidized premiums financed through general tax revenues	Capitation for primary providers; CBGs for hospitals	Accredited public and private facilities
Nigeria	NHIS (1999)	10% (2015)	**Formal sector workers:** 15% payroll tax split between employees (5%) and employers (10%)	Capitation and fee-for-service	Public and private facilities
Philippines	PhilHealth (1995)	91% (2016)	**Formal sector workers:** payroll tax **Informal sector workers:** fixed premiums **Poor:** subsidized premiums	Capitation for primary providers; fee-for-service for hospitals	Accredited public and private facilities

Sources: HFG, n.d., 2015, and 2014; Feleke et al., 2015; NHIA, n.d.; Ibraimova et al., 2011; MOH, 2015; Ramana et al., 2013; Tandon et al., 2016; Wright, 2015; Windmeyer, 2017a, 2017b, and 2017c; JLN, n.d.; Chakraborty, 2013.

Is family planning included in each benefits package?

In 2017, HP+ consulted with experts and conducted a literature review to propose basic and a comprehensive packages of family planning services—including short-acting, long-acting reversible, and permanent methods as well as counseling—that could be purchased by health insurance schemes and other payers. Table 2 presents findings of the family planning benefits included in each country's health insurance scheme, compared to HP+'s suggested basic and

comprehensive packages (HP+, 2017a). Overall, all of the selected countries, with the exception of Ethiopia, have included some family planning methods and counseling in their health insurance schemes—however, none of the schemes cover all methods in the suggested family planning packages.

Table 2. Family Planning Benefits Covered in Seven Countries Compared to HP+ Proposed Basic and Comprehensive Packages

Package/Country (Scheme)	Family Planning Counseling	Short-Acting Methods					Long-Acting Reversible Methods		Long-Acting Permanent Methods	
		Injectables	Oral Contraceptives	Condoms	Emergency Contraceptives	Vaginal Ring	Implants	Intra-uterine devices	Female Sterilization	Male Sterilization
Basic (HP+ proposal)	✓	✓	✓	✓	✓		✓	✓	✓	
Comprehensive (HP+ proposal)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ethiopia (CBHI)							✓			
Ghana (NHIS)	✓		✓	✓						
Indonesia (JKN)	✓						✓	✓	✓	✓
Kenya (NHIF)	✓	✓	✓				✓	✓		
Kyrgyzstan (MHIF)		✓	✓							
Nigeria (NHIF)		✓	✓	✓				✓		
Philippines (PhilHealth)							✓	✓	✓	✓

Sources: Guiffrida et al., 2013; HP+, 2017a; HP+ 2017b; Mathew, 2017; NHIF, 2015; Windmeyer, 2017a, 2017b, and 2017c; Wright, 2015; PhilHealth, 2014.

Many countries' schemes included family planning in benefits packages indirectly, either by inclusion in a stated essential benefits package that the government supports and the insurance scheme ostensibly adopts (as in Kenya and the Philippines); a mandated medicines and commodities list that doesn't explicitly mention services (as in Kyrgyzstan); or by specific legislative orders not necessarily replicated in operational benefits-related language (as in Ghana and Nigeria) (NHIF, 2015; NHIA, n.d.; Jurczynska, 2017). In practice, family planning integration in insurance schemes is challenged by lack of supplies, provider ignorance of available family planning benefits, lack of insurance beneficiaries' knowledge of their rights, and the presence of informal/unauthorized fees for services that should be free at the point of service. For instance, in Ghana, user fees are exempted by law but not enforced (AS4H, 2016; NHIA, n.d.). Poor supply-chain management and stagnation in the quality of family planning delivery was seen in Indonesia (Mathew, 2017). Ineffective communication to providers and members was seen in Nigeria (HP+, 2017b). Challenges have also been documented in the Philippines, where realization of family planning inclusion in PhilHealth has been slowed by several factors—a temporary restraining order, issued by the Supreme Court, on procuring, selling, distributing, dispensing, and administering some contraceptive methods; a lack of clarity in guidelines for specific service inclusion; and misalignment between reimbursable procedures and Department of Health licensing requirements (PhilHealth, 2014; FP2020, 2017; USAID/Philippines, 2018).

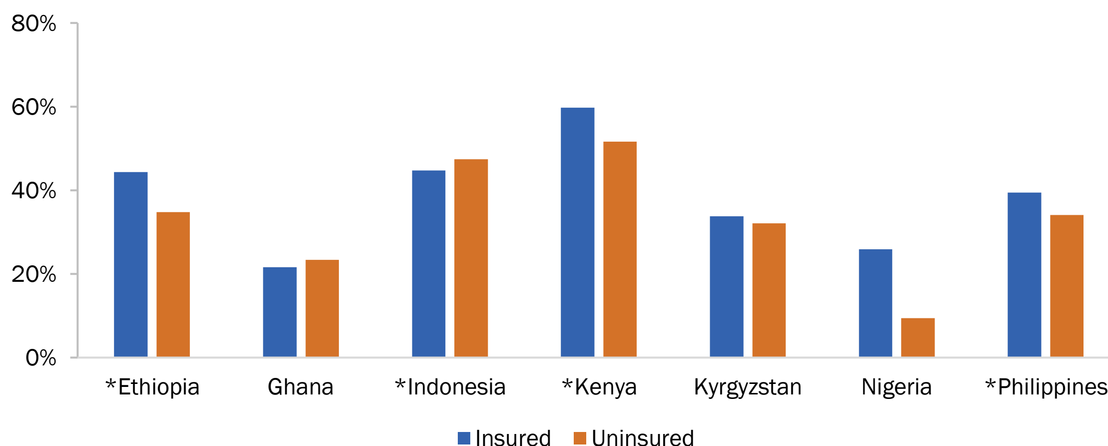
Relationship between Insurance Status and Family Planning Access Indicators

To better understand the relationship between family planning indicators and health insurance status, results from analyses of DHS and Indonesia's *Susenas* surveys are presented below. Based on the data in the most recent available survey year, HP+ considered mCPR, method mix, and source of method.

Is mCPR higher among insured women?

As stated earlier, insurance coverage has often been associated with higher rates of service utilization. Similarly, HP+ expected that insurance coverage of family planning services would be associated with higher levels of mCPR, due to reduced financial barriers to access. However, the analysis suggests mixed evidence of such a relationship—the mCPR among married, reproductive-aged women was higher among the insured than the uninsured in five of the seven countries (see Figure 1). In Ethiopia, Kenya, and the Philippines, where insurance coverage was associated with greater use of modern contraceptives, the difference between groups was statistically significant. In Ethiopia, this association was found despite the fact that family planning is an exempted service, provided free-of-charge to all clients in public health facilities and not reimbursed by CBHI. The difference between insured and uninsured mCPR was highest in Nigeria, with a higher mCPR among insured women, though this result was not statistically significant. In Ghana and Indonesia, mCPR was higher among uninsured women, though the difference between groups was not statistically significant in Ghana. Similarly, in Kyrgyzstan, insurance status appeared to have little bearing on mCPR among married women, and the difference between insured and uninsured was not statistically significant.

Figure 1. mCPR by Insurance Status among Married Women



* Statistically significant difference between insurance groups ($p < 0.05$).

Do insured women use permanent and long-acting reversible contraceptive methods more than uninsured women?

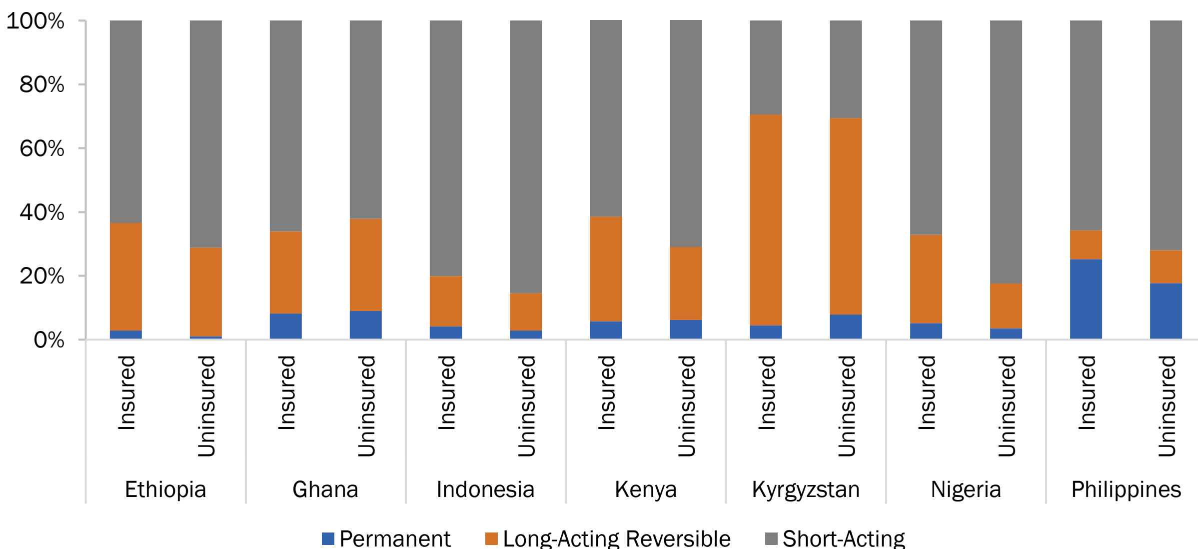
HP+ expected that beneficiaries of insurance schemes would have higher rates of use of permanent methods and long-acting reversible contraceptives (LARC), due to lower upfront costs. The analysis shows that LARCs were used more by insured than uninsured women (see Figure 2). Specifically, in five of the seven countries, intrauterine devices (IUDs) and implants

had the largest difference in use, being higher among insured than uninsured women; however, this difference is only statistically significant in Indonesia. In Ghana and the Philippines, the use of LARCs and permanent methods was higher among uninsured than insured women. In Ghana, the NHIS benefits package only includes short-acting methods, which may explain why use of short-acting methods was higher among insured than uninsured women. Similarly, the Philippines only offers implants and female sterilization through the PhilHealth scheme, which may explain the utilization differences for these methods.

Use of short-acting methods (including condoms, oral contraceptives, injectables, and other modern methods) was higher among uninsured than insured women in all countries, except Ghana and Kenya. In Ethiopia, Indonesia, Nigeria, and the Philippines, difference in use was largest for injectables and oral contraceptives, with use higher among uninsured women. In Kyrgyzstan, female sterilization had the highest difference in use, with uninsured women using sterilization more than insured women.

In Ethiopia, Indonesia, Kenya, and Kyrgyzstan, findings suggest that insurance coverage was associated with higher utilization of specific contraceptive methods included in respective benefits packages. Only in Nigeria did utilization of specific methods not align with included coverage under NHIS.

Figure 2. Method Mix by Insurance Status among Married Women

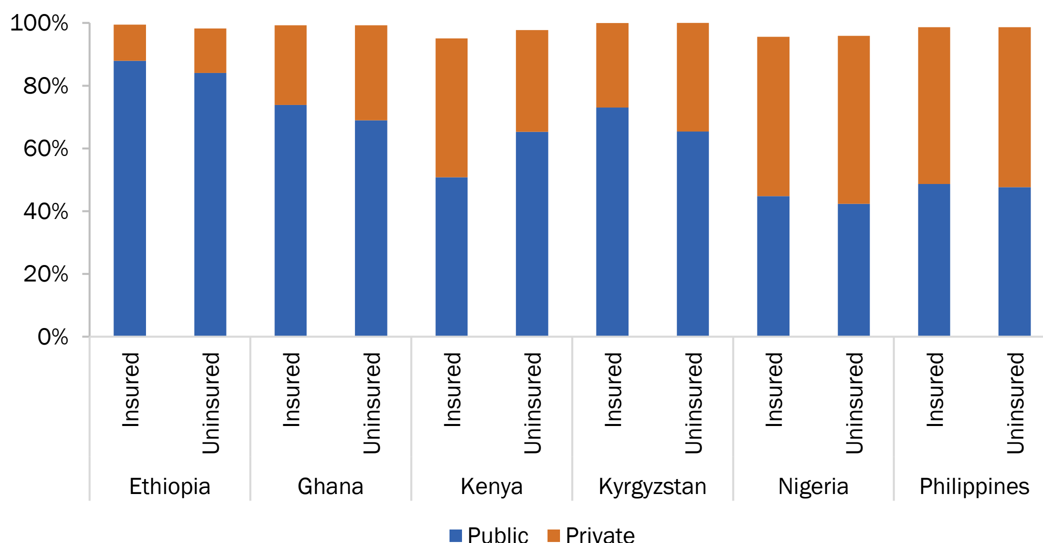


Is use of the private sector for contraception higher among insured women?

Finally, HP+ considered source (public or private) of contraceptive method last used among modern contraceptive users in six of the seven countries—Indonesia was excluded from this analysis because *Susenas* data does not include source of provision of last method used. For schemes that contract both private- and public-sector providers, HP+ expected that the private sector as a share of method source would be higher due to reduced financial barriers to access in these facilities. Better access to and patient preference for private facilities may contribute to why patients select private facilities over public facilities when both are covered by insurance (Agha and Do, 2009; Hutchinson et al., 2011).

The analysis shows that all of the health insurance schemes contract public and private facilities, with the majority of modern contraceptive users acquiring their last method from public facilities in four of the six countries (see Figure 3). Only in Nigeria and the Philippines did more users report private facilities as their last source of contraception. In Ethiopia, Ghana, and Kyrgyzstan, the proportion of insured women who procured their last modern method from a public-sector provider is higher than that of uninsured users. Whereas in Kenya, the proportion of public relative to private sector use is higher among uninsured women. In Nigeria and the Philippines, this difference is negligible.

Figure 3. Last Source of Modern Contraception by Insurance Status among Married Women



Insurance and Health Equity in the Family Planning Context

This section compares family planning access indicators' association with insurance status across wealth quintiles to understand whether insurance may be effective at reducing financial barriers, and subsequently increasing family planning access, among the poor. Nigeria is excluded from this analysis because stratification by insurance status and wealth quintile with DHS data yields too small a sample size for estimation.

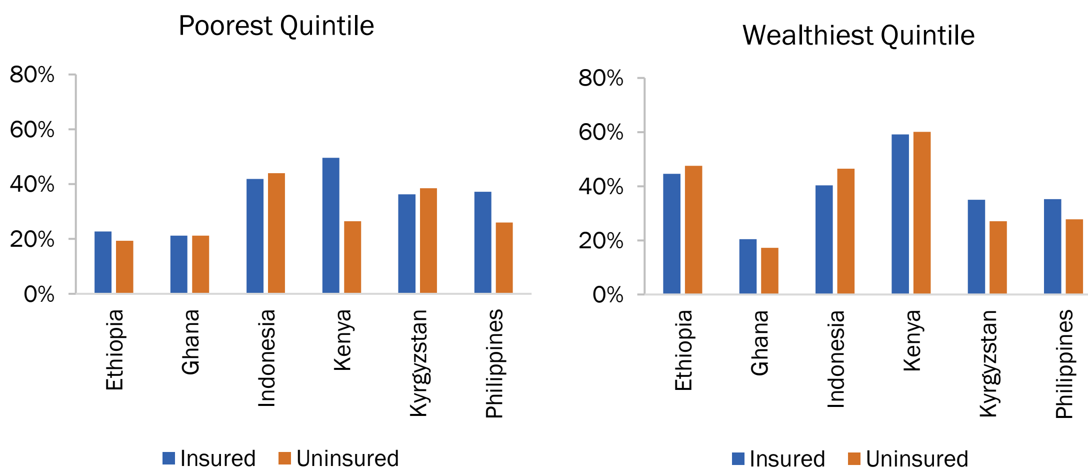
Does mCPR of the poorest and wealthiest differ among insured versus uninsured women?

HP+ expected that mCPR difference between insured and uninsured would be greater in the poorest/lowest quintile than the wealthiest/highest quintile, due to greater financial barriers to access among the poor. In all studied countries, with the exception of Indonesia, mCPR is higher among wealthier women, compared to poorer subgroups (Track20, n.d.; Teplitskaya et al., 2018). Figure 4 illustrates the variation in mCPR by insurance status among married women in the lowest and highest quintile, respectively. After stratifying by insurance status, mCPR was found to be higher among insured than uninsured women in the poorest quintile in Ethiopia, Kenya, and the Philippines. The difference between mCPR among insured and uninsured women in the poorest quintile is greatest in Kenya, differing by 23 percentage points, followed by the Philippines (11%), and Ethiopia (3.4%). In the other countries, mCPR does not differ significantly for the poor across insurance status.

The mCPR of women in the highest wealth quintile was greater among insured relative to uninsured women in Ethiopia, Kyrgyzstan, and the Philippines. However, the difference between insured and uninsured mCPR was small; Kyrgyzstan had the highest difference, at eight percentage points.

These results can be used to assess whether insurance status is promoting health equity; that is, whether the difference in mCPR between the highest and lowest socioeconomic groups is lower among those with insurance than those without. This difference of mCPR in the wealthiest relative to the poorest quintile in each country is greater among the uninsured in five of the six study countries. Only in the Philippines was the difference between mCPR in the wealthiest and the poorest quintiles greater among insured than uninsured women. Overall, this suggests that family planning inclusion in insurance benefits packages may promote higher mCPR among the poor and, thereby, greater health equity.

Figure 4. mCPR by Wealth Quintile and Insurance Status among Married Women



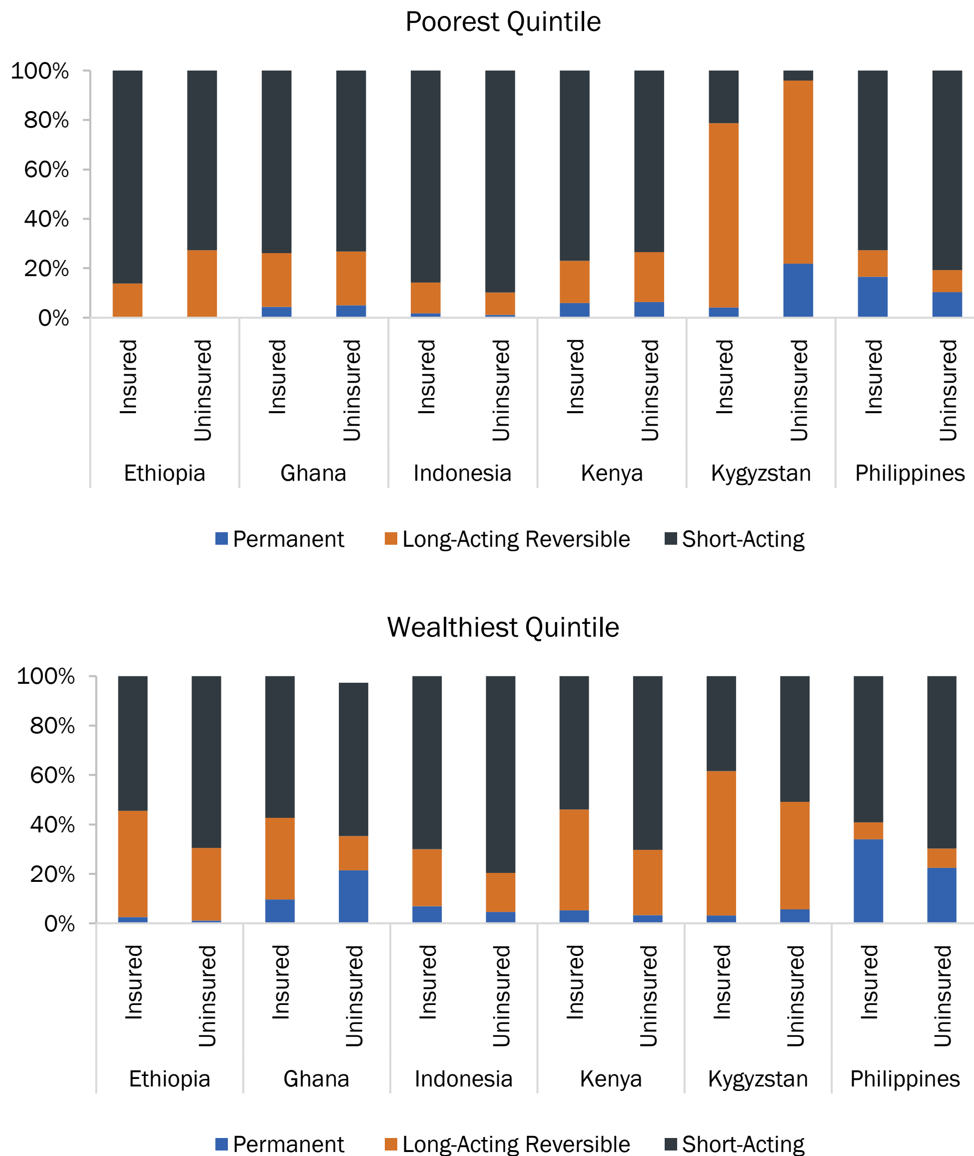
Are wealth and insurance coverage associated with greater use of long-acting and permanent contraceptive methods?

Due to the higher cost of these methods, HP+ expected that wealthier women, regardless of insurance coverage, would use LARCs and permanent methods more than poorer women; HP+ also expected that among the poorest quintile, use of LARCs and permanent methods would be greater among insured than uninsured women. Limited evidence provided earlier in this analysis suggests that insurance coverage is associated with greater use of LARCs and permanent methods within the modern method mix. Assuming that insurance would promote equity across socioeconomic categories, HP+ also expects that the difference in the proportional use of LARCs and permanent methods (relative to all methods) between the wealthiest and poorest quintiles would be higher among uninsured than insured women.

In general, the analysis showed that use of LARCs and permanent methods was greatest among women in the wealthiest quintile (see Figure 5) and, in all countries analyzed, use of LARCs and permanent methods was higher among insured women than uninsured women. Contrary to what was expected, among users in the poorest quintile, only in Indonesia and the Philippines was use of LARCs and permanent methods higher among insured than uninsured women. The

evidence did not substantiate that insurance was associated with a smaller difference in use of LARCs and permanent methods across wealth quintiles. Only in Kyrgyzstan is the difference between use of LARCs and permanent methods greater in uninsured groups.

Figure 5: Method Mix by Wealth Quintile and Insurance Status among Married Women

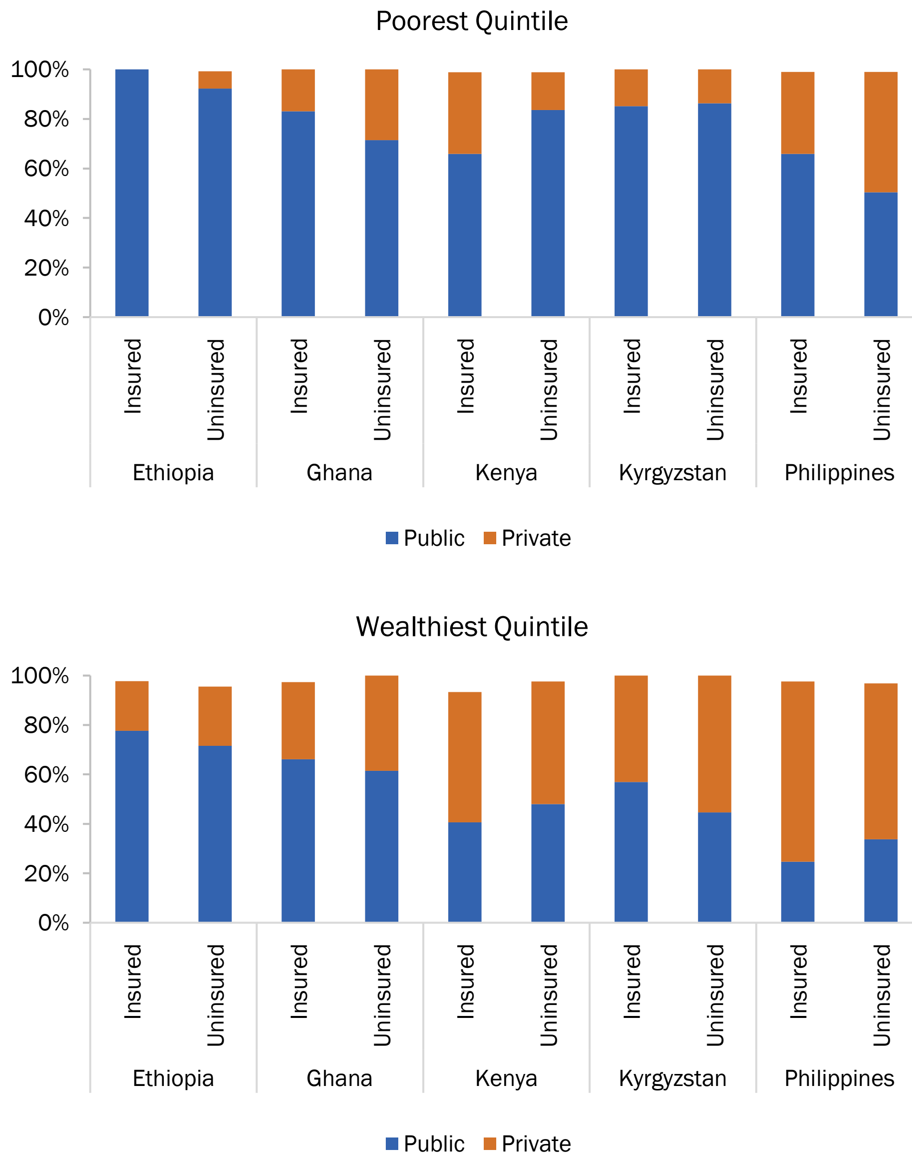


Does insurance increase access to the private sector for poorer family planning users?

HP+ expected that wealthier women would use the private sector more than poorer women do, as they face lower financial barriers to access and are able to pay out-of-pocket for services in the private sector, which are—or are perceived to be—of higher cost. Additionally, HP+ expected that, among the poorest quintile, use of the private sector would be higher among insured compared to uninsured women. As before, Indonesia is not included in this analysis, as source data was not collected in *Susenas*.

Overall, use of the private sector was higher among the wealthiest quintile than the poorest, regardless of insurance status. However, as noted previously, in all studied countries the majority of women, regardless of insurance coverage, used the public sector to acquire their contraceptive methods. This is particularly pronounced among women in poorer quintiles (see Figure 6). Reliance on the public sector is partially explained by the limited contracting of private providers by the schemes in these countries, particularly in Ethiopia. Only in Kenya did insured women, in both the poorest and wealthiest quintiles, use the private sector more than uninsured women did.

Figure 6: Last Source of Modern Contraception by Wealth Quintile and Insurance Status among Married Women



Conclusions

The analysis reinforces that the relationship between insurance coverage and family planning indicators is not solely dependent on formal inclusion in a benefits package. All the analyzed countries have government-supported insurance schemes oriented toward UHC achievement that include, or plan to include, family planning services in their benefits packages (although in most cases, the realization of family planning integration into insurance benefits packages have been hindered). The results show that inclusion of family planning services in benefits packages may promote higher mCPR by mitigating financial barriers to access. Further, insurance can promote the use of specific contraceptive methods covered in the scheme. As such, the analysis further highlights the need to consider the incentives faced in accessing and providing family planning services as part of inclusion in UHC efforts.

Given the relatively disparate results from the analysis compared to what was expected, the following are several potential explanations.

- Many countries have reformed or implemented insurance schemes that enroll populations easiest to reach, such as those in the formal sector, who often have the greatest ability to pay for family planning services. Without insurance, they may or may not be faced with financial barriers to access.
- Despite the formal inclusion of family planning services in all of the benefits packages examined, actual integration of these services has faced challenges. This is particularly true in Ghana, Nigeria, and the Philippines, where unauthorized fees, lack of capacity, and limited political will, respectively, have limited the availability of family planning services in practice (AS4H, 2016; HP+, 2017b; FP2020, 2017).
- Payment mechanisms need to be evaluated to assess incentivization of family planning services through insurance. The predominance of capitation schemes at the primary healthcare level does not incentivize providers to increase the number of family planning users, though it may contribute to the shift toward provision of long-acting methods.
- Reliance on public facilities as sole affiliated providers for many insurance schemes may limit utilization. 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.
- Service delivery context, social-cultural norms, preferences, costs, presence of external donors, and other financing schemes (vouchers or conditional cash transfers) are not accounted for in this analysis.

Understanding family planning incorporation into UHC-oriented schemes and how coverage under these schemes may be associated with family planning utilization is fundamental to leveraging schemes to improve family planning uptake and sustainability. This analysis does not establish a causal relationship between expanded insurance and increasing modern contraceptive usage. Yet, the results demonstrate that these schemes have the potential to improve family planning access. Proper targeting of populations with the greatest financial barriers, alignment of provider incentives to promote and provide family planning services, and reductions in non-financial barriers to access are needed for insurance to facilitate greater family planning uptake. Further investigation of the determinants of family planning utilization within specific country contexts is necessary to tailor governments' inclusion of family planning services within national health insurance schemes.

References

Abera Abaerei, A., J. Ncayiyana, and J. Levin. 2017. "Health-care Utilization and Associated Factors in Gauteng Province, South Africa." *Global Health Action* 10(1): 1305765.

Abt Associates Inc. 2017. *Supporting Family Planning within Universal Health Coverage Initiatives*. Bethesda, MD: Abt Associates Inc.

Agha, S. and M. Do. 2009. "The Quality of Family Planning Services and Client Satisfaction in the Public and Private Sectors in Kenya." *International Journal for Quality in Health Care* (2): 87-96.

African Strategies for Health (AS4H). 2016. "Health Insurance Profile: Ghana." Available at: http://www.africanstrategies4health.org/uploads/1/3/5/3/13538666/country_profile_-_ghana_-_us_letter.pdf.

Avenir Health. Unpublished. "Supporting Family Planning Within National Health Financing Schemes: Kenya Case Study."

BPJS Kesehatan. 2018. "Jumlah Faskes dan Peserta." Available at: https://bpjs-kesehatan.go.id/bpjs/index.php/jumlahPeserta.

Chakraborty, S. 2013. UNICO Studies Series 22 Philippines' Government Sponsored Health Coverage Program for Poor Households. Washington, DC: World Bank.

Dalinjong, P.A., P. Welaga, J. Akazili, A. Kwarteng, M. Bangha, et al. 2017. "The Association Between Health Insurance Status and Utilization of Health Services in Rural Northern Ghana: Evidence from the Introduction of the National Health Insurance Scheme." *Journal of Health, Population, and Nutrition* 36:42. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5728048/.

Demographic and Health Surveys. n.d. "Datasets." Available at: https://dhsprogram.com/data/available-datasets.cfm.

Fagan, T., A. Dutta, J. Rosen, A. Olivett, and K. Klein. 2017. "Family Planning in the Context of Latin America's Universal Health Coverage Agenda." *Global Health: Science and Practice* 5(3): 382-398.

Family Planning 2020 (FP2020). 2017. "Family Planning 2020 Commitment: Govt. of Philippines." Available at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/08/Govt.-of-Philippines-FP2020-Commitment-2017-Update.pdf.

Feleke, S., M. Worki, H. Zelelew, and T.D. Ashagari. 2015. *Ethiopia's Community-based Health Insurance: A Step on the Road to Universal Health Coverage*. Bethesda, MD: Health Finance and Governance Project, Abt Associates, Inc.

Giedion, U., E.A. Alfonso, and Y. Díaz. 2013. *The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence*. UNICO Studies Series, No. 25. Washington, DC: World Bank.

Giuffrida, A., M. Jakab, and E.M. Dale. 2013. *Toward Universal Health Coverage in Health: The Case of the State Guaranteed Benefit Package of the Kyrgyz Republic*. Washington, DC: World Bank.

Health Finance and Governance Project (HFG). 2014. “Case Study: Kenya National Hospital Insurance Fund (NHIF): Premium Collection for the Informal Sector.” Available at: http://healthmarketinnovations.org/sites/default/files/Case%20Study%20Kenya%20National%20Hospital%20Insurance%20Fund%20%28NHIF%29.pdf.

HFG. 2015. “Ethiopia Scales Up Community-based Health Insurance.” Available at: https://www.hfgproject.org/ethiopia-scales-community-based-health-insurance/.

HFG. n.d. “HFG at Work in Ethiopia.” Available at https://www.hfgproject.org/where-we-work/africa/ethiopia/.

Health Policy Plus (HP+). 2017a. *Essential Components of Family Planning Benefits Packages*. Washington, DC: Palladium, Health Policy Plus.

HP+. 2017b. *Financing for Family Planning in Nigeria*. Washington, DC: Palladium, Health Policy Plus.

HP+ and the National Team for the Acceleration of Poverty Reduction (TNP2K). 2018. *Healthcare Utilization Trends Under Indonesia’s National Health Insurance Scheme: 2011-2016*. Washington, DC: Health Policy Plus.

Holtz, J. and I. Sarker. 2018. *Integrating Family Planning into Universal Health Coverage Efforts*. Bethesda, MD: Abt Associates, Sustaining Health Outcomes through the Private Sector Plus Project.

Hutchinson, P.L., M. Do, and S. Agha. 2011. “Measuring Client Satisfaction and the Quality of Family Planning Services: A Comparative Analysis of Public and Private Health Facilities in Tanzania, Kenya, and Ghana.” *BMC Health Services Research* 11:203.

Ibraimova, A., B. Akkazieva, E. Manzhieva, and B. Rechel. 2011. “Kyrgyzstan: Health System Review.” *Health Systems in Transition* 13(3): 1–152.

Joint Learning Network for Universal Health Coverage (JLN). n.d. “Philippines: Expanding the Depth and Breadth of Coverage.” Available at: http://www.jointlearningnetwork.org/countries/philippines.

Jurczynska, K. 2017. *Evidence and Advocacy: Unlocking Resources for Family Planning in Nigeria*. Washington, DC: Palladium, Health Policy Plus.

Kazungu, J.S. and E.W. Barasa. 2017. “Examining Levels, Distribution and Correlates of Health Insurance Coverage in Kenya.” *Tropical Medicine & International Health* 22(9):1175-1185.

Machiyama, K., F. Obare, V. Chandra-Mouli, D. Chou, M. Festin, et al. 2017. *Family Planning Evidence Brief: Accelerating Uptake of Voluntary, Rights-Based Family Planning in Developing Countries*. Geneva, Switzerland: World Health Organization.

Mathew, J. 2017. *The Essential Package of Health Services and Health Benefit Plans in Indonesia*. Bethesda, MD: Abt Associates Inc., Health Finance and Governance Project.

Mazzili, C., G. Appleford, and M. Boxshall. 2016. *MSI's Health Financing Assessments 2012-2015: What Did We Learn About UHC Financing and Contraception? Four 'Ps' Matter*. Marie Stopes International. Available at: https://mariestopes.org/media/2689/msi-4ps-matter-in-contraception-health-financing.pdf.

Ministry of Health, Republic of Indonesia (MOH). 2015. "Indonesia Health Profile 2014." Jakarta, Indonesia: Government of Indonesia.

National Health Insurance Authority (NHIA), Ghana. n.d. *2013 Annual Report*. Available at: http://www.nhis.gov.gh/files/2013%20Annual%20Report-Final%20ver%2029.09.14.pdf.

National Health Insurance Fund (NHIF), Kenya. 2015. "NHIF Benefit Package: Explanation of the Benefit Package for the National Scheme." Available at: http://www.nhif.or.ke/healthinsurance/uploads/customers/benefitspackage.pdf.

"National Health Insurance Scheme." n.d. Available at https://cdn.modernghana.com/images/content/report_content/NHIS.pdf.

Philippine Health Insurance Corporation (PhilHealth). 2014. "Benefits." Available at: https://www.philhealth.gov.ph/benefits/.

Ramana, G., R. Chepkoech, and N. Walelign. 2013. *Improving Universal Primary Health Care by Kenya: A Case Study of the Health Sector Services Fund*. UNICO Studies Series, No. 5. Washington, DC: World Bank.

Sharma, S. 2018. "Purchasing Family Planning Services." PowerPoint presented at the Attaining Sustainable Financing for Family Planning in Sub-Saharan Africa meeting in Accra, Ghana, January 2018.

Shihab, A.N., A. Nurdin, A. Kadir, H. Thabrany, and I. Paturusi. 2017. "National Health Insurance Effects on Inpatient Utilization in Indonesia." *International Journal of Health Sciences and Research* 7(4):96–106.

Tandon, A., E.S. Pambudi, P. Harimurti, E. Masaki, A.W. Subandoro, et al. 2016. *Indonesia -- Health Financing System Assessment: Spend More, Right, and Better*. Washington, DC: World Bank.

Teplitskaya, L., R. Ross, and A. Dutta. 2018. *Has Indonesia's National Health Insurance Scheme Improved Family Planning Use?* Washington, DC: Health Policy Plus.

Track20. n.d. "Technical Brief: Family Planning Estimation Tool." Available at: http://track20.org/download/pdf/Track20%20Technical%20Briefs/english/Technical%20Brief_FPET%20(2015%2004%2013).pdf.

USAID/Philippines. 2018. *Addendum #3: Health Equity and Financial Protection Platform. Annual Program Statement No. 72049218APS00001: Improved Health for Underserved Filipinos*. Available at: https://www.grants.gov./web/grants/search-grants.html?keywords=72049218APS00001%20.

World Health Organization (WHO). 2017. "Health Systems: Universal Health Coverage." Available at http://www.who.int/healthsystems/universal_health_coverage/en/.

Windmeyer, L. 2017a. *The Essential Package of Health Services and Health Benefit Plans in Ethiopia*. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

Windmeyer, L. 2017b. *The Essential Package of Health Services and Health Benefit Plans in Ghana*. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

Windmeyer, L. 2017c. *The Essential Package of Health Services and Health Benefit Plans in Nigeria*. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

Wright, J., 2015. *Essential Package of Health Services Country Snapshot: Kenya*. Bethesda, MD: Health Financing & Governance Project, Abt Associates Inc.

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