



Health Insurance and Priority Services: How Do We Make It Work?

Increasing access to and utilization of priority¹ and preventive health care services is critical to improve health outcomes and reach the Millennium Development Goals (MDGs). For example, high fertility leads to increase risk of maternal mortality and increased poverty and high maternal mortality leads to increased risk of infant mortality. In most countries, there is political desire to improve access to and utilization of priority services to reduce fertility, improve maternal health outcomes, and improve child health outcomes. Financing these priority and preventive health care services, however, often proves to be difficult because of the limited tax revenues, inefficient use of funds, and poverty.

National Health Accounts (NHA) data show us that household out-of-pocket spending for priority services is much higher than governments or donors realize. While not the only factor that contributes to utilization of these essential services, the cost of health care, particularly out-of-pocket expenses, does constitute a significant barrier to accessing the services, particularly among the poor. This barrier then affects the demand for and utilization of services. High out-of-pocket expenses also make people financially

¹ Priority services are considered the most important and critical services that target specific health conditions or a specific target group. Priority services include: maternal and child health, reproductive health/family planning, and communicable disease prevention. They also include preventive services, or services that are intended to prevent a health condition from escalating into a catastrophic case. "Catastrophic" is defined as a health care cost that is severe enough to affect one's financial stability and/or socio-economic status.

vulnerable to catastrophic events and increasing poverty.

Health insurance mechanisms pool risks for health care costs and have the potential to reduce or eliminate point-of-service costs. They are increasingly being created and expanded in developing countries to help achieve a variety of objectives. Some countries implement health insurance to reduce the risk of people falling into poverty from high out-of-pocket health care costs. Others want to protect and improve health through increasing utilization of services, including priority services.

The purpose of this brief is to discuss the concepts of health insurance, the practice of designing and implementing health insurance, and discuss whether priority services "fit" within a health insurance scheme. It also provides examples of countries that have tried to include priority services in the insurance benefits package, and discusses critical success factors that have affected the outcomes of these schemes.

The country examples that are highlighted demonstrate that under the right circumstances, and if done correctly, health insurance programs can successfully cover priority health care services and can effect change in utilization of these services, in turn improving the health status of covered population.

I. HEALTH INSURANCE RISKS: WHAT ARE THEY?

Health insurance is the collection and management of financial resources so that large, unpredictable, unforeseeable events or financial risks of each individual become predictable at the group level and are distributed across a diverse group. In other words, certain health events that are unknown and have unpredictable expenditures qualify as “insurable risks” and are therefore “insurable”. Health services that fall under this definition generally include catastrophic care, or high-cost care that is needed because of an unforeseen occurrence.

There is substantial empirical evidence that exists regarding the economic and social impacts of adverse health shocks and the need for policies to provide everyone, but particularly the poor, with financial protection against large, unpredictable costs.² Therefore, the attention that health insurance has received in recent years in developing countries is understood and good.

What is less empirically clear is the effect on health shocks of policies to provide everyone with financial protection against known, high-frequency, health care services, such as priority health care services. This is an important consideration, as many countries introduce health insurance not only to reduce the risk of catastrophic health care costs, but also to improve population health through increasing utilization of health care services across the board, including priority health care services.

² Wagstaff, Adam. 2005. *The Economic Consequences of Health Shocks*. World Bank Policy Research Paper 3655, Washington: DC.

II. DO PRIORITY SERVICES, SUCH AS REPRODUCTIVE, MATERNAL, AND CHILD HEALTH FIT INTO HEALTH INSURANCE? SHOULD THEY BE INSURED?

Given the above, what does this mean for priority health care services, such as reproductive, maternal and child health? Technically speaking and according to the definition, most priority health care services (such as family planning, antenatal care, and immunizations) do not fit under the pure definition of health insurance mainly due to their predictability.

However, for many countries, their objective of establishing health insurance includes protecting health and reducing the risk of requiring catastrophic, inpatient care. To achieve these objectives, it may be necessary to consider including these “non-insurable” services within the benefits package. While many people refer to an expanded benefits package that includes known, frequent, low-cost services as health insurance, it is in fact a form of “prepayment” scheme. Prepayment schemes have benefits packages that include what is traditionally considered “non-insurable” services, such as priority services. Prepayment schemes may also include an insurance portion, which covers catastrophic, insurable risks. Many people use the term “health insurance” to refer to both true health insurance schemes and prepayment schemes.

If priority services are included, careful consideration to some key issues is required.³ The determination of a benefits package will depend on the structure of revenues (sources of funds), payment mechanisms

³ *Calling a scheme that includes non-insurance risks “insurance” may be somewhat of a misnomer given the definition of insurance. Many schemes are in fact social security schemes, or simply prepayment schemes. They may have an “insurance” component to them, which pools risks to cover for unpredicted health costs. Further, it is possible to create a benefits package that is purely primary health care, to include preventive care. The drawback to this approach is that it does not serve the basic function of health insurance – to protect individuals from unexpected, unpredictable high costs associated with disease or injury through spreading the risk for those costs across a large group of individuals.*

(capitation, fee schedules, etc.), and delivery structure (gate-keepers, primary care groups, utilization review, etc.) that may be implemented as part of the insurance scheme. All of these characteristics will affect the way in which the expanded benefits package is costed, as well as the feasibility and ease with which the expanded benefits package can be executed.

There are advantages and disadvantages to including priority services in the benefits package. Operationally, it is much more difficult to include low-cost, high-frequency services since these will require a more extensive review and billing process, a much more frequent information exchange, and much higher administrative costs. Therefore, expanding a benefits package to include priority services may require a phased approach to ensure that the system operationally can handle the increased capacity. As the operation of insurance becomes more efficient, and the sources of funding are more closely aligned with the expected system costs, a more generous benefits package may become possible.

Despite some of these operational considerations, there are many reasons to believe a relationship exists between health insurance enrollment and the use of priority health care services. The first is that health insurance can increase the service utilization. Health insurance can reduce financial barriers to accessing health care services because it reduces the point-of-service costs, which are often too high for individuals to cover when needed. Long-term methods of family planning, considered priority services, have high up-front costs, which can limit access to utilization.⁴ Because insurance is a prepayment scheme,⁵ and

therefore reduces or eliminates costs at the time of service, people are more inclined to utilize health services that are pre-paid, opposed to paying at the time of care.^{6,7}

Second, health insurance can make services more available. If priority services are not covered by the insurance scheme, and the individual's willingness to pay and ability to pay is less, then providers will be less willing to provide these priority services. Insurance plans have the potential to assist governments and donors to organize the funds, purchase these services from providers, and ensure the quality of services. Since these services are paid by the insurance scheme, services will be more available to the enrolled population.

Third, if preventive measures are taken (as is the case with priority health care services), then the long-term costs of health care should go down. For example, if a woman is able to prevent an unplanned pregnancy, the cost of abortion, the costs of delivery, the infant and child costs, in addition to the longer-term societal costs, could go down. Further, if antenatal care is provided to pregnant women, the risks and costs associated with complicated delivery and emergency care is greatly reduced.

There are many reasons to justify the inclusion of priority services in a benefits package. Many countries have incorporated priority services in the benefits package and have valuable lessons that can be shared with others that are going down that path, as well.

4 Stover, John and Laura Heaton. 1999. Famplan Version 4. A computer program for projecting future family planning requirements. The Futures Group International.

5 Prepayment refers to insurance members paying for average expected costs (among the risk pool) in advance, relieving them of uncertainty and ensuring compensation should a health risk occur (Gottret, P. and George Scheiber. 2006. Health Financing Revisited. World Bank: Washington DC).

6 Eklund, Per and Knut Stavem. August 1990. Prepaid financing of primary health care in Guinea-Bissau: An assessment of 18 village health posts. The World Bank.

7 Schneider, P, F.P. Diop, and S. Bucyana. March 2000. Development and implementation of prepayment schemes in Rwanda. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

III. EXPERIENCES OF INCLUDING PRIORITY HEALTH SERVICES IN HEALTH INSURANCE/PREPAYMENT SCHEMES

The case studies below present experiences from countries that have incorporated priority health care services in their health insurance/prepayment benefits package. Each country has included priority services with different objectives in mind. In some cases, there was an intentional decision to increase utilization of priority services to help achieve the MDGs. In others, the objective was to offer comprehensive health care to the population and address equity and accessibility issues.

Some countries have had great success with achieving their objectives, whether in increasing utilization or creating a more equitable health financing scheme. Other countries have not had the same success.

Each country case provides some background to the insurance/prepayment scheme, as well as a brief presentation of the services that are included in the benefits package (priority services included in the benefits package). Further we discuss the impacts of including the priority services, given the original objectives of the scheme.

After the case examples, we summarize key lessons that can be used to help other countries incorporate priority services into their insurance/prepayment packages. We also highlight critical success factors that may have contributed to the success of the schemes in achieving the intended objectives.

GHANA

Background:

Prior to 2003, Ghana financed its health care through tax revenues and user fees charged to patients at the time of service. While there were exemptions to the user fees, experience showed that user fees

substantially decreased access to health care services, particularly among the poor. Evaluations determined that the exemptions were being applied unevenly and that the poor still faced financial barriers to accessing needed services.

To help overcome the financial barriers, community-based health insurance programs (CBHI) began appearing throughout the country and increased substantially between 2001 and 2003 (47 CBHI programs in 2001 and 168 in 2003). While the CBHI covered only about 1% of the population in 2003, it was clear there was a need and demand for a formalized health financing mechanism to spread the costs of health care across a group of people.

This demand prompted the government to explore abolishing user fees and implementing a national health insurance scheme. In 2003, the government began introducing policies to exempt women from delivery fees in public, private, and mission facilities. Along with this change, the government passed the National Health Insurance Act, which aimed to provide universal coverage to all Ghanaians within five years. The scheme was to be nationally mandated in all districts. By 2007, approximately 42% of the population was covered by the insurance scheme.

Benefits package

The National Health Insurance Scheme (NHIS) currently provides coverage for basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and cesarean), eye care, dental care, and emergency care.

Initially, certain public health services were excluded from the benefits package because they were considered “essential public goods” and were being provided free by the government. These services include family planning and immunizations⁸ As of July 8 In reality, constrained budgets are failing to cover all the operational costs of facilities, so nearly all public and private facilities charge fees for family planning

2008, all pregnant women became eligible and exempt from premium contributions for the insurance scheme. In September 2008, all children under 18 became eligible for the insurance scheme regardless of whether their parents were enrolled. Women are entitled to free antenatal care services, free delivery care (for either normal delivery or cesarean), as well as free care for their babies up to one year of age (women are able to also receive family planning services at the same clinic, but must pay out-of-pocket).

Recently, the government and other stakeholders have considered the costs of including family planning in the benefits package, to include long-term and permanent family planning methods as well as injectables. A recent cost-benefit study found that if family planning is covered in 2009, by 2011 the NHIS will save almost US\$ 11 million that year alone and save up to US\$ 17 million by 2017 (cost savings would come from decreased fertility, averted births, and lower costs associated with birth).⁹

Outcomes/impact¹⁰:

An evaluation of the health insurance scheme was done in two of the districts, Nkoranza and Offinso. It was found that the proportion of women with delivery in the past 12 months who were insured at time of delivery increased from 30% in 2004 (baseline) to 45% in 2007, which in essence means that the number of people who are covered by insurance increased between the two years. Further analysis found that women of reproductive age from wealthier households enrolled in the NHIS at higher rates, compared with women from poorer households: 16% of women from poorest quintile were enrolled, compared with 48% of women from richest quintile.

products.

⁹ Smith, M. and A. Fairbanks. 2008. *An Estimate of Potential Costs and Benefits of Adding Family Planning Services to the National Health Insurance Scheme in Ghana and Impact on the Private Sector*. Report prepared for the Policy, Planning, Monitoring and Evaluation Division, Ministry of Health, Government of Ghana.

¹⁰ Outcomes/Impact for Ghana is from Hatt, L., S. Chankova, and S. Sulzbach. 2009. *Maternal Health in Ghana: Investigating the Impact of the National Health Insurance Scheme on Maternal Health Indicators*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Despite a greater number of people enrolling in the scheme, the analysis found that there was no significant change in the proportion of women receiving prenatal care between baseline and endline, indicating that the NHIS did not increase utilization of prenatal care. Prenatal care in Ghana was already high during baseline, which may be one of the reasons for the lack of change (96% in 2004).

The proportion of women delivering in a facility also did not change significantly during the first few years of the insurance scheme (from 54.5% to 54.9%). Further, multivariate analysis (controlling for socio-economic characteristics known to be associated with maternal health seeking behavior) suggests that the NHIS is not associated with change in the likelihood that a woman delivered in a health facility. Also the distribution of deliveries that took place in the private, public, or mission facilities did not change.

Although it appears that reducing financial barriers to care through the NHIS did not have an impact on the utilization of maternity care in this case, it was found that since the initiation of NHIS, out-of-pocket expenditures decreased by approximately one-third, a significant change in household expenditures. Further, average expenditures on prenatal care also declined (not statistically significant). Also, the proportion of women who did not have to pay anything for their prenatal care increased from 8% to 43%.

COLOMBIA

Background:

The Government of Colombia transformed its health care system in 1993 with the enactment of a law that transitioned from a supply-based health care model to a managed care insurance model. To facilitate universal health care to all Colombians, there were two health insurance schemes that evolved: a contributory insurance scheme and a subsidized insurance scheme.¹¹

¹¹ Prior to the reforms, the general Social Security System (ISS) guaranteed universal emergency care and general health services including family planning, prenatal, and delivery care services for workers, their spouses, and children under one year of age.

The former system, called the Health Promotion Enterprises (EPS), covers those with the ability to contribute and is financed through employer and employee contributions through a tax of 12% of income (note that the scheme includes the formal and informal sector; anyone who chooses to participate may, as long as they have the ability to adequately contribute). One-twelfth of these funds are used to finance the subsidized scheme, called the Subsidized System Administrator (ARS). ARS funding is supplemented by the decentralized political entities, such as departments (responsible for hospital services), municipalities (responsible for primary care), and Ministry of Health. Members of the ARS also contribute resources on a sliding scale based on income and some beneficiaries contribute nothing.

Members of ARS are generally poorer than those members of EPS. Anyone, however, can join the EPS plan, as long as they are able to pay to participate. EPS enrollment entitles members to a wider range of services at notionally higher quality. The ARS benefits package is more limited, but still covers prevention and primary health care (including family planning and maternal health services).

Benefits:

In addition to catastrophic care, both the EPS and ARS schemes provide coverage for family planning services, as well as maternity care, including prenatal services, delivery and puerperal care, and nutritional assistance to mothers. Coverage is provided for everyone including pregnant and nursing women and their children up to one year of age (even the poor who may not be contributing to the scheme).

Members of EPS receive services in “higher quality” government facilities and private facilities; members of ARS receive services in the government-owned public facilities.

Outcomes/Impact:

Generally speaking, the introduction of universal health

insurance appeared to have contributed positively to the improvement of reproductive health services. For example, there was an increase in physician-assisted deliveries (up 66%), deliveries in health facilities (up 18%) and use of prenatal care among rural women (up 49%). (All from Demographic and Health Survey data: 1986, 1990, 1995, 2000.)

In general, there was not a large variation in the proportion of women who used modern family planning methods¹² across the two insurance types. The women with EPS were slightly more likely to use modern methods of family planning than those without insurance, but the difference was nominal. One note is that in Colombia, access to high-quality, inexpensive family planning services already existed from the NGO Profamilia. This may explain why insurance does not seem to have played a role in increasing family planning utilization. The ARS insurance plan did not seem to have an effect on modern family planning use. However, the study does find that ARS coverage significantly increases the probability of using a clinical method of family planning, versus a resupply method.

Women who were members of the EPS insurance scheme were more likely to receive prenatal care and give birth in a facility than those without insurance. Those with ARS were only slightly more likely to receive prenatal care and deliver in a facility. This may be the result of ARS members only having access to the public sector facilities, rather than the higher-quality private facilities.

BOLIVIA¹³

Background:

Bolivia began implementing a public health insurance scheme in 1996 with what started as the National Maternal and Child Insurance program (SMNM). Bolivia

¹²Modern methods are those that require supplies or clinical services. They include: contraceptive sterilization, intrauterine devices, hormonal methods, oral pills, condoms, and vaginal barrier methods.

¹³Much of the data in this case is from Pooley, B., M. Ramirez, and C. de Hilari. 2008. “Bolivia’s Health Reform: a response to improve access to obstetric care. *Studies in HSO&P*.”

was facing high levels of maternal and infant mortality and the aim of the insurance program was to increase coverage of health care services for women and children, improve quality of service, improve equity, and increase efficiency and effectiveness of the health care delivery system¹⁴

Shortly after the launch of the SMNM, the scheme was expanded to cover more services and was renamed the Basic Health Insurance Scheme (SBS). In 2002, the government expanded the program even further to include more benefits/services within the package. The name was then changed to the Universal Mother and Child Insurance Scheme (Seguro Universal Materno Infantil, SUMI).

Technically, SUMI is not an insurance scheme, but rather a health financing mechanism that offers a package of free services provided universally, which the population can access through all public health service providers. Clients have to register at first contact and receive an identification card, which allows access to free services anywhere in the country. All types of providers are able to participate, including NGOs and other faith-based organizations.

SUMI pools resources from three different sources: municipality (local government), departments, and national government. Ten percent of local revenue (from municipalities) is allocated to pay for SUMI services. Departmental funds pay for health service personnel. The National Solidarity Fund (financed through debt relief) helps strengthen SUMI financing. If the municipality has funds remaining, they are used for social investments, including infrastructure or other activities related to maternal and child health. In 2006, municipalities received US\$ 22 million for payment of SUMI services: this national policy commitment and financial support has assured the economic sustainability of the program.

¹⁴ Maceira, D. 2007. *Actores y reformas en salud en America Latina, nota técnica de saúde. No. 1/2007*, Banco Interamericano de Desarrollo, Washington DC.

Benefits:

The focus of SUMI is to increase access to services among the more vulnerable population groups, specifically women and children. As such, the services offered are in line with maternal, reproductive, and child health care.

Initially, the (SMNM) insurance package included 32 health issues, covering maternity care including cesarean and normal deliveries and pediatric care for cases of diarrhea and respiratory infections. Under SBS, the benefits package was expanded to cover 92 health issues. In addition to the previous 32 issues, SBS covered obstetric emergency transport, newborn care, child nutrition, and development screening, vaccination, and care for infectious diseases other than diarrhea and pneumonia, such as sepsis and meningitis.¹⁵

When SBS was expanded to SUMI, the coverage increased to 547 health issues, including those that affect pregnant women (starting at beginning of pregnancy to six months after childbirth; covers children from birth to 5 years of age). In 2006, services were further expanded to incorporate 27 additional sexual and reproductive health service packages, including family planning and cervical cancer screening, protecting women up to 60 years of age.

Outcomes/Impact:

Through SUMI, Bolivia was able to meet some tremendous targets that were established by the government in cooperation with the World Bank (which helped finance the management of the scheme). By 2007, they had met four of the eight projected indicators: early neonatal mortality reduction, uptake of iron supplementation, and coverage of pneumonia cases and immunizations.

Further coverage of four antenatal care visits and institutional delivery was greatly improved under SUMI

¹⁵ Bohrt, R and Holst, J. 2002. *Evaluación del seguro básico de salud en Bolivia con la metodología InfoSure. Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Bolivia.*

(compared with previous two programs). However, it was the initial program (SNMN) that saw the greatest improvement in these indicators. Since then, the indicators have steadily improved and are now plateauing. There is no data yet to show the impact of the additional sexual and reproductive health services that were included in 2007.

While access to services increased, it wasn't across the board and services did not extend to the poorest sectors of the population, especially in rural areas. Only one-third of pregnant women from rural areas completed four antenatal care visits, while 70% of urban women completed four visits. Further, neonatal coverage (well-baby check-up before one month of life) was only 6% in rural areas, whereas it was close to 94% in urban areas. However, the coverage of under-5 (measured as 1 doctor's visit per year) was 10% higher in rural areas compared with urban areas (56% vs. 44%).¹⁶ Further, cesarean rates did not change in rural areas since the beginning of the scheme.

While economic barriers have been mitigated through SUMI, challenges continue in equity and social exclusion because of geographic inaccessibility, insufficient human and technical resources mostly in rural areas, and cultural aspects of community and providers.

IV. CRITICAL SUCCESS FACTORS TO INCLUDING PRIORITY SERVICES IN HEALTH INSURANCE/PREPAYMENT SCHEMES

Health insurance/prepayment schemes can be effective in reducing financial barriers to accessing priority services, such as family planning, immunizations, and maternal and child health services. However, reducing financial barriers to accessing priority services does not automatically translate directly into increased utilization of the priority services, nor into more

equitable access to services. Some experiences demonstrate success in increasing utilization and access to priority services through health insurance/prepayment although often equity issues persisted.

What is important to gain from these experiences, however, are the processes by which the country was able to include the priority services, as well as some of the lessons learned that contributed to the success of the schemes to improve utilization and health outcomes. With each of these examples, there are lessons learned of how to facilitate successful implementation of an expanded health insurance/prepayment package that includes priority services.

Below, we present some of what we call the 'critical success factors' to including priority services in health insurance/prepayment, such as:

- Factors that encouraged countries to include priority services in the benefits package;
- Factors that contributed to whether inclusion of priority services affected uptake or utilization of services; and
- Factors that contributed to the impacts realized by including priority services in the benefits package.

DESIGN AND TYPE OF INSURANCE/PREPAYMENT

The type of health insurance/prepayment model applied has implications on coverage with priority health services. Among other things, the source of funding affects the decision-making process of which benefits are included in the insurance/prepayment scheme. For example, with a privately financed insurance/prepayment model, it is important that the payers (employees in an employer-based scheme, or communities in a microinsurance scheme) demand priority services and be willing to pay for them if those services are to be included in the benefits package. For publicly funded programs and social insurance programs, the policymakers must be convinced of

¹⁶ Pooley et al. (2008). *Idem*.

the value of adding priority services to the benefits package design and motivated to take on the necessary actions to make it happen.

The types of providers who participate in the model also make a difference on whether priority services coverage is feasible or not. The closer the providers are to the covered population and the more service delivery points there are, the greater the impact there will be on access to services. The type of provider payment mechanism also makes a difference and can help facilitate the provision of priority services, such as family planning. For example, in Nigeria, a USAID-funded project developed a strategy to expand and improve the provision of family planning and reproductive health products and services in the private health sector. The introduction of the National Health Insurance Scheme (NHIS) presented an opportunity to address the needs of private providers participating in the scheme and to encourage them to promote family planning and other priority services included in the scheme. The NHIS utilized a preferred provider model, where beneficiaries choose their primary care provider who then receives a set capitation fee every month for basic services. This provides an incentive for providers to keep their patients healthy and to manage their costs effectively.

INFORMATION DISSEMINATION/OUTREACH

Information dissemination and outreach is a critical component of successful health insurance/ prepayment. While this is true for all health insurance/prepayment models and benefits packages, it is particularly important when benefits packages include priority health care services, as one of the objectives is to increase utilization of priority services. Beneficiaries must understand what services they are covered for under the health insurance/prepayment scheme, understand where they can access services, and understand the fee structure in advance of accessing services (for example, if there is a co-payment).

Effective information dissemination also allows the scheme to expand and attract new members, which creates a large pool of persons among whom to spread the costs and risks. For example, in Peru, a USAID-funded project called Apoyo a Programas de Población (APROPO) was implemented to expand family planning programs in the private sector and increase the number of insurance companies and employers who offer family planning services. The project was unsuccessful in attracting new users to the insurance scheme primarily because of ineffective communication and information dissemination practices; therefore it was not possible to determine the effect of health insurance coverage on family planning use.¹⁷

CONTENT OF BENEFITS PACKAGE

There is no gold standard when it comes to developing a health insurance/prepayment benefits package; however, what is known is that the benefits package must meet the needs of the population for it to be perceived useful. This is particularly true when beneficiaries are expected to contribute to the scheme. Therefore it is critical that the contents of a benefits package meet the needs of the intended beneficiary group.

In addition, an expensive component of health insurance/prepayment is the operational costs to educate and enroll beneficiaries. If beneficiaries, particularly the poor, do not see a value added to participating in a scheme – which may be the case with a benefits package that only covers catastrophic care, because the chance of experiencing a catastrophic health condition is rare – there is the likelihood that people will drop out of the scheme and not renew their membership. In contrast, a benefits package that provides coverage for services that beneficiaries need on a regular basis, provides a greater incentive to renew the membership.

¹⁷ Lambert, A. M.N. Favin, V.M. Jaramillo, and J. Zavala. 1994 Evaluation of USAID/Peru Project: Private commercial family planning project.

Discontinuing health insurance membership can put considerable strain on a health insurance/ prepayment scheme's viability, so maximizing renewal rates is a serious consideration. Ensuring the benefits package includes services that are demanded and needed by the beneficiary population will help them realize the value-added of the scheme and increase the likelihood of renewal.

QUALITY OF SERVICES AND PROVIDER CAPACITIES

A health insurance/prepayment scheme is really only as good as the quality and accessibility of health care services to the beneficiary population. If the quality of services that are provided by the insurance scheme is poor, beneficiaries will not utilize them, regardless of whether they are free or not. This is evidenced by the fact that even in systems where services are provided free of charge in public facilities, the poor will often pay for services in the private sector because of the increase in quality.

Quality is a function of many variables and we will not address all of them here. One variable, however, is the ability of the provider to take on the demand for services, both in number and in type. For example, if an insurance/prepayment benefits package is expanded to include clinical methods of family planning, but the local participating provider does not have the abilities to deliver these services, including that service in the insurance/prepayment package is not effective. Effective planning can help counter this by ensuring that you have providers participating in the scheme who can offer the priority services within the benefits package. As was discussed in the blueprint guide, provider planning is critical to be able to meet the demand for increased utilization of services with health insurance.

Ghana is currently in the process of trying to include family planning in its national health insurance scheme; however it seems to be facing a potential provider quality situation. A survey of providers in Ghana

suggests that including family planning in the benefits package will not be an easy endeavor; providers there believe that including family planning in the insurance/ prepayment scheme will increase utilization and are concerned they do not have the capacity to meet the new demand with high-quality services. Further, commodity security would need to be strengthened to ensure that supplies meet the new demand. Quickly jumping into including family planning in Ghana, then, may compromise quality of services. Effective planning to ensure the providers have the capacities necessary to meet the increased demand and ensuring supplies are available would help Ghana in transitioning to including this important service.

FACILITATING DELIVERY OF DRUGS AND CONSUMABLES AT PROVIDERS' LEVEL

It is necessary to have a supply system both at national and local levels that allow health personnel to get the drugs and consumables required to deliver the priority services, such as family planning commodities and other consumables required for obstetric and neonatal emergencies. If a participating provider does not have access to the needed commodities for services that are included in the benefits package, there is no real benefit to including the service within the insurance/ prepayment package.

Most countries struggle with delivering commodities and supplies to all providers, particularly those in more remote locations. Stock-outs and other logistical challenges could compromise the impact on utilization that would have been observed otherwise.

AVAILABILITY OF FREE SERVICES IN PUBLIC FACILITIES (THROUGH DONOR FUNDS)

Expanding health insurance/prepayment benefits can sometimes be costly, given all the administrative duties necessary to manage a successful insurance/ prepayment scheme. While the cost of including new, low-cost services is quite nominal, the costs to ensure that the system can respond to the added service

INCLUDING PRIORITY SERVICES IN HEALTH INSURANCE: THE CASE OF FAMILY PLANNING

Globally, an estimated 210 million pregnancies occur each year, of which 60 million end in abortion or with the death of the mother or baby.¹ Over 500,000 maternal deaths and 4 million neonatal deaths occur annually; more than 54 million women suffer diseases or complications due to pregnancy and childbirth. The need for family planning (FP) is of great importance; however, unmet need for FP is rampant throughout the world. In sub-Saharan Africa, it is estimated that 19.4% of women would like to avoid becoming pregnant but are not using contraception.²

Given these staggering statistics, it is important to increase access to and utilization of FP services. One way is through health insurance/prepayment mechanisms.

Why include FP in insurance benefits package? Including FP in the benefits package of insurance/prepayment schemes make sense for several reasons:

Cost-effectiveness: FP is cost-effective.³ An averted pregnancy can prevent health care costs associated with other conditions or ailments. Inclusion of FP in insurance is important from a cost perspective because averting a birth also reduces future fertility, and DALYs saved can exceed the gains possible from the health benefits to just one generation.

Improve knowledge and social acceptance: Inclusion of FP in health insurance can provide a platform for educating and counseling beneficiaries on the use of FP. Its inclusion in health insurance benefits packages can also improve social acceptance of FP.⁴

Meet beneficiaries' health needs: When a health insurance benefits package is based on beneficiary needs, there is a greater chance for the success of the insurance scheme because of beneficiary compliance with the scheme, and increased demand and renewal rates of the insurance policy (in voluntary schemes). The high rate of unmet need for FP is a red-flag that barriers to FP access exist. Inclusion of FP, therefore, could increase the attractiveness of health insurance, as it includes coverage for a desired product, making the insurance scheme more feasible to implement and sustain.

Merit Good: Although FP services are consumed by private individuals, the services have profound externalities (external benefits and/or costs) and are therefore often considered "merit goods," which are the health needs that are defined by the experts and society that everyone should have regardless of willingness and ability to pay. Including these types of services into a health insurance benefits package can ensure their availability and utilization.

Efficiency of delivery: If the FP services are included in the health insurance package, the services can be organized and delivered through the existing health insurance provider networks, which will make the service delivery more efficient.

Specific complexities of including FP into health insurance: Despite the gains to be made in including FP in health insurance, FP brings specific complex issues to the table.

Politics: The politics of FP has been contentious for decades, and this has affected its sustainability and funding. Health insurance is not immune to the politics of FP. Prioritizing services to be included in health insurance can come under great scrutiny, which opens the door for political adversaries to voice opinions of whether to include (and promote) FP through health insurance.

Funding gaps: Because FP is considered a merit good, which is often defined by need rather than by demand, the willingness to pay from the consumers may not be sufficient to cover the services defined in the benefits package. If insurance relies on the premium contribution from the enrollee, funding gaps may stand in the way of including FP. Further, many countries omit FP as a benefit in health insurance indicating that the public health care system will provide it free of charge to all those who need. For example, in Ghana, FP was determined to be an "essential public good," and would be offered "free" through the Ghana Health Service (GHS). However, because constrained budgets failed to cover all basic operational costs at the facility level, almost every public facility and all private facilities charged fees for FP products.⁵

Opportunities to include FP in health insurance benefits packages: Despite the difficulties, there are very important reasons to include FP in health insurance benefits packages. Below we present a few ways in which stakeholders can help get FP covered:

Bundling with other services: FP does not have to be a stand-alone service that is provided to all beneficiaries. For example, to alleviate some of the political challenges that can surface, some countries have bundled FP services into other packages of services, such as postpartum services. Preventing pregnancy immediately following birth is an important public health consideration that generally has public and medical support. Counseling women at this time about the use of FP can be an effective way to include FP in the benefits package.

Advocacy: Generating demand for FP coverage can be one of the most effective ways to get FP covered by health insurance. Depending on the model of health insurance, different stakeholders may be involved in determining the benefits package so it is important to target messages to the appropriate audience (Ministry of Health, employers, insurance agency, etc.).

Funding guidelines: In decentralized settings, resource decisions belong to local governments, which can result in FP not being adequately addressed. In Bolivia, where decision making has been decentralized to 311 municipalities, the central government has developed guidelines to ensure that funds are allocated in accordance with national priorities. Based on these guidelines, for example, local governments have to allocate a specific percentage of revenue to the universal health insurance program for mothers and children. Without such guidance, programs such as FP might be underfunded.⁶

1 Levine, Ruth, Anna Langer, Nancy Birdsall et al. 2006. *Contraception*. Chapter 57 in Dean T. Jamison et al., eds. 2006. *Disease Control Priorities in Developing Countries*.

2 Idem. Washington, DC: The World Bank and Oxford University Press.

3 See Idem. Also: Stover, J., J. Bertrand, S. Smith, N. Rutenberg, and K. Meyer-Ramirez. 1996. *Empirically Based Conversion Factors for Calculating Couple-Years of Protection*. Chapel Hill, NC: The Futures Group; Mauldin, W.P. and V.C. Miller. 1994. *Contraceptive Use and Commodity Costs in Developing Countries, 1994–2005*. New York: United Nations Population Fund; Pritchett, L.H. 1994. "Desired Fertility and the Impact of Population Policies." *Population and Development Review* 20 (1): 1–56; Hughs and McGuire. 1996. "The cost-effectiveness of family planning." *Journal of Public Health Medicine* 18(2): 189–196.

4 Casterline, S.W. and J.B. Sinding (2000) identified social disapproval and lack of knowledge of FP to being two of the main reasons for unmet need. J. B. Casterline and S.W. Sinding. 2000. "Unmet Need for Family Planning in Developing Countries and Implications for Population Policy." *Population and Development Review* 26: 4 691–723

5 Private Sector Partnerships (PSP)-One. 2008. *Banking on Health Explores Adding Family Planning Services to the Ghana National Health Insurance Scheme*. <http://psp-one.com/content/announcements/detail/5215/>

6 Egan, T. 2008. *Family Planning Challenges and Decentralization of Health Services in Latin America*. Population Reference Bureau web site: <http://www.prb.org/Articles/2008/familyplanning-latinamerica.aspx>

Banking on Health conducted a cost-benefit analysis of adding coverage of long-term and permanent FP methods and injectable contraceptives to the Ghana NHIS benefits package. The analysis revealed that including FP would cause a decrease in fertility and would avert births that otherwise would have cost the NHIS considerable expenditures. According to the assumptions, if FP is covered in 2009, by 2011 the NHIS will realize almost US\$ 11 million in net savings in that year alone. Source: Private Sector Partnerships (PSP)-One, <http://psp-one.com>

(such as logistics supply and provider capacity) may not outweigh the benefits. This is particularly true in settings where donors are financing service provision of priority services free of charge, or for very low cost, such as the case with family planning services.

Further, a country where many priority services are offered free of charge may see only a marginal increase in utilization of services through the insurance/prepayment scheme. This is not to suggest that in situations where donor support is significant for the provision of priority services that the country does not find alternative means to finance priority services. However, it is important to recognize this and understand if the impact observed is marginal, that there might be a good reason for it.

MONITORING SYSTEMS

A results-driven approach and focus on accountability can help facilitate project implementation and follow-up, particularly at lower levels of the health care system, which is often where priority services are delivered. Improvement in information systems is essential to enable monitoring of indicators and assess if insurance policy is reaching the poor. Further, need for standardized indicators to facilitate compatibility of information systems at different levels of system.

CONCLUSION

Health insurance/prepayment is a mechanism that can help facilitate the provision of priority health care services. While the availability of empirical evidence to show the impact of including priority services in an insurance/prepayment benefits package is limited (i.e. does including priority services in insurance increase utilization), insurance/prepayment is a way to help finance the provision of priority health care services in a sustainable manner and to better integrate the provision of care, which is more efficient and cost-effective.

However, it is important to note that including priority services in health insurance/prepayment is not a quick fix to addressing utilization and equity issues. There are important considerations and variables that need to be addressed to maximize effectiveness, which were presented above.

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