An Online Evidence-based Course

Resources and financing on reproductive health and family planning

Implementing partners: The Department of Sexual and Reproductive Health & Research, World Health Organization (WHO) and Geneva Foundation for Medical Education and Research (GMFER)

Prepared by

Charu C. Garg Ph. D.
(charucgarg@gmail.com)

Director, Health, OJAS consulting; UNICEF and WHO consultant

Learning objectives

- Importance of understanding financing needs of SRH services including family planning in the context of international and domestic policy needs
- Analytical framework for analyzing financing needs for SRH
  - Important health financing questions
  - Resource flows – Who finances, what services, how, by how much, and for whom
  - Costs and costs effectiveness analysis
  - Equity – Who pays how much for different services
- Innovations in financing and sustainability

International policy context

- Sustainable Development Goals
  - 3, 4 and 5 – improved health, education and gender equality, respectively - depend on improvements in SRH and rights
  - include satisfying people's needs for modern contraception and family planning, reducing maternal and newborn deaths, and ending the HIV epidemic.
    - 3.1 - Reduction in maternal mortality ratio to less than 70 per live births
    - 3.7 - Improved modern contraceptive prevalence rates and demand satisfied for FP ; declining adolescent birth rates and unmet needs for family planning,
    - 5.6 - Universal access for SRH

Adding It Up: Investing in Sexual and Reproductive Health 2019 | Guttmacher Institute

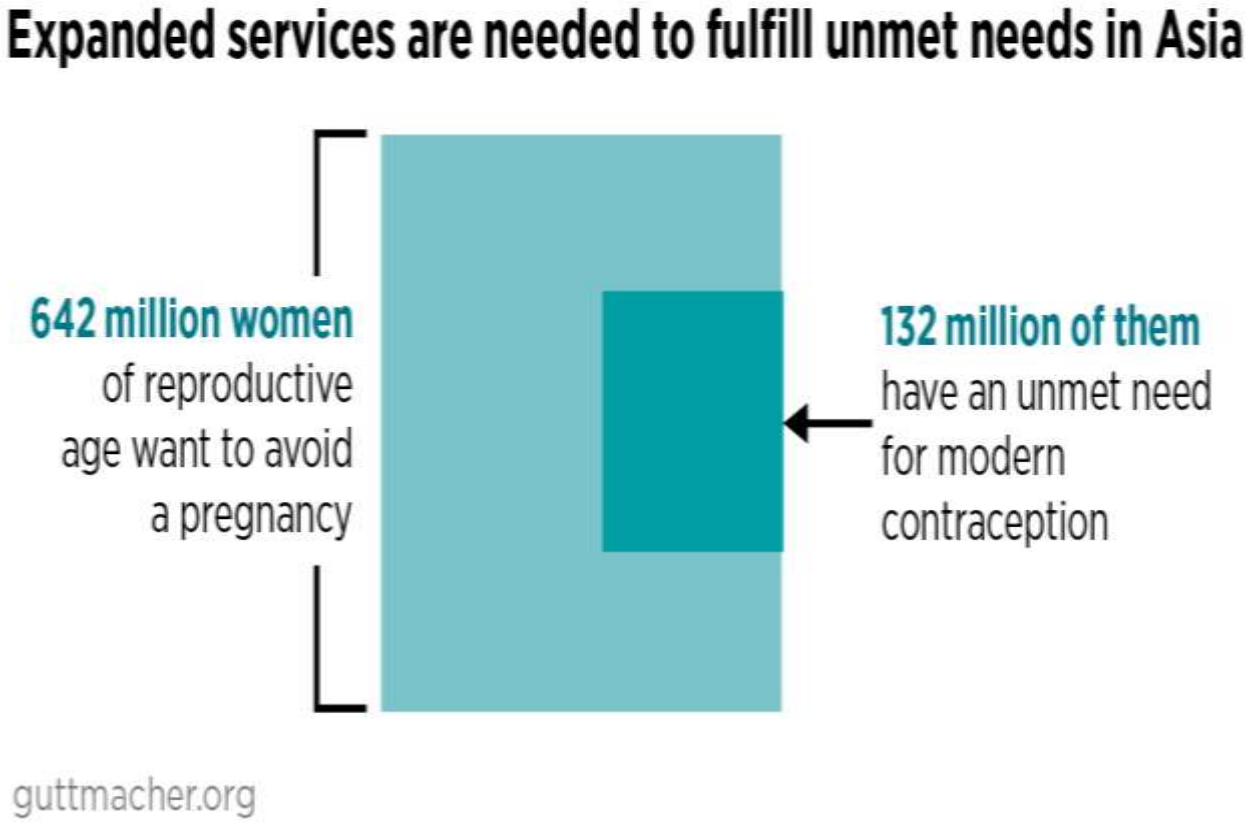
National policy context

- Assess national RH policies and goals overtime and current situation
- Better availability and access to SRH leads to better outcomes (lower no. of unintended pregnancies and unplanned births, unsafe abortions, maternal and newborn deaths, HIV infections and infertility in untreated STIs) and use of resources
- Assess keys indicators of outcomes, outputs in terms of unmet needs, inputs in terms of bottlenecks to access and allocation of financing
- To increase access, analyze SRH services delivery through three tiers of government, donors, NGOs, private sectors and identify access barriers - Availability, accessibility (financial and physical), acceptability (cultural and behavioural), coverage and actual use
  - Research shows community-based distribution of services, provision of services by community-based workers, and mobilization of resources are required to increase access to and use of SRH and maternal health services
- Analyze financing barriers to address the areas where bottlenecks exist

Policy Considerations for Financing Sexual and Reproductive Health and Rights in the Post-2015 Era – High Level Task Force for International Conference for Population and Development (ICPD); Feb 2015.

Demographics- Needs assessment

- 49% of pregnancies in LMICs are unintended
- 21% of women in reproductive age (15-49) in 36 LMICs in Asia in 2019 have unmet needs for contraceptive services, maternal care, newborn care, abortion services and treatment of major STIs. In adolescents (15-19), the unmet need is 51%

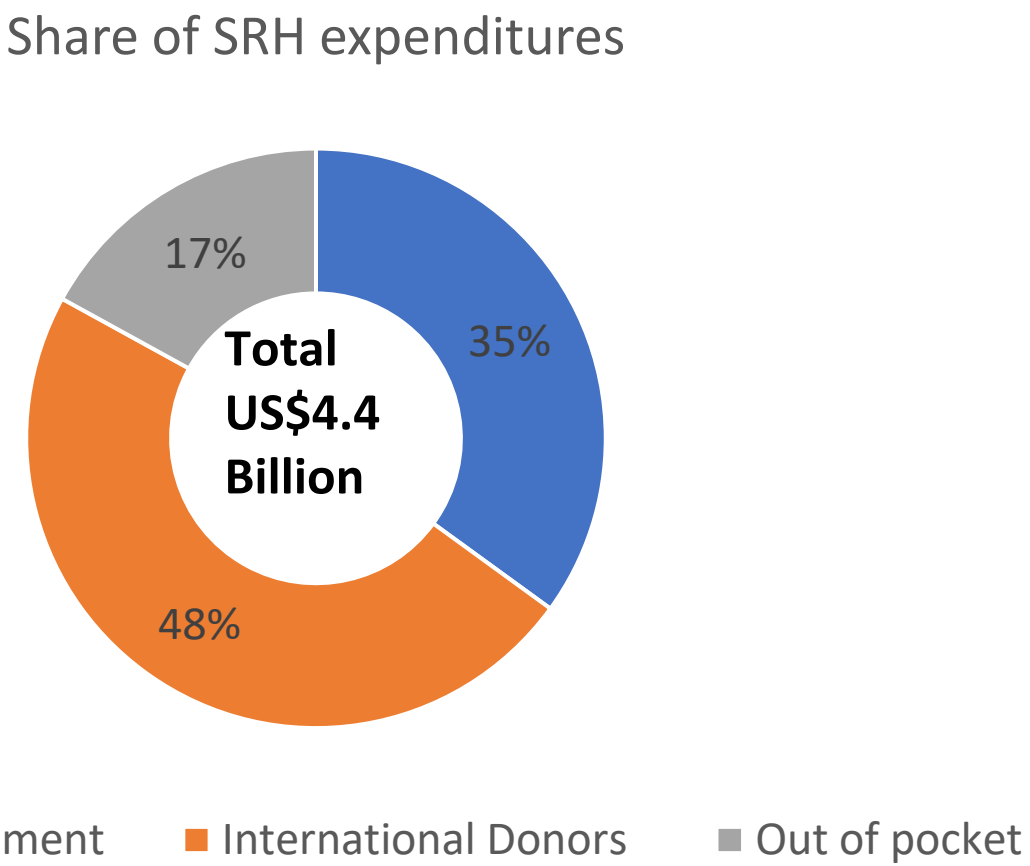


Sully EA, et al. Adding It Up: Investing in Sexual and Reproductive Health 2019. New York: Guttmacher Institute; 2020.

Financial context – Why invest in SRH?

- High Out-of-Pocket (OOP) spending in developing countries for health and SRH. (42% of all resources for SRH are OOP)
- Greater public spending and other prepaid schemes are associated with lower dependence on OOP spending for health services
- Lower OOP spending implies fewer financial barriers to the use of services
- Perceived benefits of SRH services to personal health is low - Very elastic demand
  - Less likely to use unless subsidized
  - A small increase in price reduces the demand
- Public good - Large positive externalities and societal value
- Spending on SRH is Cost effective
- Other international agendas (for example HIV) have reduced the financing for FP

Distribution of family planning expenditures by sources of funds in 69 FP2020 countries in 2018



Finance | Progress Report 2020 (familyplanning2020.org)

Analytical Framework for Financing SRH Services

Important financing questions for SRH services

RESOURCES	• What resources are available for SRH from different sources and their distribution by services, providers and region?
COSTS	• What are the costs for scaling up SRH services? • Methodology for measuring costs of the program: by types of services, inputs or combination • Costs of introducing new policy guidelines
COSTS EFFECTIVENESS	• What is the population health impact of scaled-up programmes and at what costs? • Assess which specific SRH services are more cost effective compared to others to improve SRH outcomes at lower costs?
EQUITY	• Are these programmes reaching the intended vulnerable and most-in-need groups? • How can financial access be measured and improved – Equity in access, impoverishment and catastrophic health expenditures
SUSTAINABILITY AND POLICY	• What is the potential for sustainable scaling up of pilot programmes? • What are the implications for programmes and policies for scaling up community-based and health care financing programmes?

Areas where information is required for analyzing financing needs for SRH

- Analyze financing in the overall context of coverage and utilization of services; supply of services; and health seeking behavior of the population.
- Analyze the population trends and demographic needs specific to SRH.
- Analyze macroeconomic situation and fiscal space for SRH services.
- Assess financing for SRH services in the context of health sector financing, available budgets, costs of services, resources required and funding gaps.
- Financing to address the areas where bottlenecks exist.

Assessment of overall Macro Fiscal Situation and Fiscal Space available for SRH

Fiscal Space can be defined as ***room in a government´s budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.*** (Heller P, 2005, IMF)

Recent and Projected trends in Gross Domestic Product (GDP) growth	• Higher GDP growth can imply higher government revenues, even if Revenue to GDP ratio is constant.
General Government spending (GGE) to GDP ratio Tax to GDP ratio	• Shows whether the government has funding to finance health and SRH in general • Capacity to raise taxes and thereby more resources for Health and SRH
Government budget deficit and Government debt to GDP ratio	• Budget deficit implies that expenditures are greater than revenues which implies that government capacity to raise resources is limited. • Continuous budget deficit leads to high debt to GDP ratio.

Also assess funding by different levels of government and if there is flexibility to shift expenditure under different budget heads.

RESOURCES: Analysis for making decisions on sources of financing and on resource allocation (1)

- **What financing sources (where the money comes from) are used for financing SRH services?**
  - Direct and indirect taxes collected by Central and provincial governments
  - Financing from corporate funds (profits)
  - Financing from households either through NGOs or direct out of pocket (OOP) for services
  - Financing from external - bilateral or multilateral sources

Total government expenditures and private expenditures are determined not by sources of financing but by financing schemes. Funds managed by government are called government financing/expenditures and those managed by private agencies are called private financing/expenditures.

RESOURCES: Analysis for making decisions on sources of financing and on resource allocation (2)

- **What financing schemes (defined by who manages the funds) are used for financing SRH services?**
  - Government schemes – Funds managed by government agencies and directly paid for services provided by government or private sector
  - Insurance - Social insurance (managed by government agencies) and private insurance schemes (managed) by private agencies
  - Firms/ corporate sector - e.g., through corporate social responsibility or paying for employees' health
  - NGOs – Domestic or international NGOs managing funds to finance or provide services (generally private financing)
  - Direct OOP payments by households for services sought from public or private providers (private financing)

Total government expenditures and private expenditures are determined not by sources of financing but by financing schemes. Funds managed by government are called government financing/expenditures and those managed by private agencies are called private financing/expenditures.

RESOURCES: Analysis for making decisions on sources of financing and on resource allocation (3)

- **What services are being financed, by whom and how much?** - treatment/prevention; long-term/ short-term family planning commodities, SRH services (e.g., safe abortion and post abortion care)
- **Where services are provided or purchased from** - urban/rural, hospital/primary care facilities/ pharmacies
- **Who is providing them?** - formal clinical staff/informal healers; public/private/ International and domestic NGO managed facilities
- **What services are being paid for by whom**

Total government expenditures and private expenditures are determined not by sources of financing but by financing schemes. Funds managed by government are called government financing/expenditures and those managed by private agencies are called private financing/expenditures.

Analyzing health expenditure pattern for SRH

How much is spent on health and SRH – Key indicators

- Total Health Expenditures (THE) %GDP;
- Government health expenditure (GGHE) %GDP;
- Per capita GGHE;
- GGHE % GGE;
- GGHE%THE;
- Private Health expenditures %THE;
- External health expenditures %THE;
- OOPE%THE;
- Health insurance exp % THE

- For SRH
  - Allocation to SRH % THE
  - Per capital spending for SRH
  - Govt and Private share for SRH

Health financing arrangements / Pooling

- Assess different financing mechanisms
  - Funds spent by different levels of govt.
  - Funds through social or private insurance agencies
- Direct OOP payment or
- Development financing for services
- Identify Which services are financed how and to what extent.

Purchasing and resource allocation decisions

- Expenditures by each activity/ function for the SRH Program (by Govt and OOP)
  - For modern contraception
  - Maternal and newborn care
  - Abortion services (safe abortion and post abortion care)
  - STI treatment
  - Others
- By type of providers- Level of facilities and for public and private separately
- Allocation by different income quintiles
- Allocation between different geographical areas, between regions - rural and urban areas
- Purchasing by age group, if available

Assess trends and composition. Assess different Supply side and demand side financing arrangements e.g. insurance, contracting, pay for performance, cash transfers and vouchers, etc.

Costs: Different costs types

- **Economic or financial costs, or both**
  - **Financial costs** reflect financial outlays for goods and services needed to carry out a public health or medical intervention. Financial costs depreciate capital expenditures over time.
  - **Economic costs (aka opportunity costs)** reflect the full value of all resources utilized in producing a good or service. They represent resources consumed, that thus forgo the opportunity to devote those resources to another purpose.
- **Total or incremental costs or both**
  - **Incremental cost** is a positive difference in cost between new interventions and those already existing
- **Program specific costs only, shared costs or both**
  - Programme-specific costs" include the cost of inputs used specifically for the program and not shared with any other health services. Their utilization will be 100% for the program. All shared inputs that are part of the health system, or are used by other programs also, are not included in program specific costs.
- **Estimates recurrent, capital costs or both**
  - Capital costs have useful life of more than one year and for annual cost estimations are usually depreciated or discounted. Depreciated annual costs of capital is derived by dividing the purchase price by useful life years of the equipment. Discounted capital costs means that the net present value of capital are imputed. (https://ghcosting.org/pages/standards/glossary#D).

Costing methodologies

1. **Top-down costing** - based on the expenditures and budgets for different services and their coverage/ utilization
2. **Bottom-up costing** - for cost estimations for each activity, choose one of the following methods of estimation
   a. Analogous estimating - based on estimates for earlier projects and activities, past immunization data
   b. Expert judgement – Institutional knowledge/ data
   c. Parametric estimation – using resources/ cost items that drives the cost
   d. Ingredient approach – based on quantities times price for each input/ cost item used for the activity

Estimating costs for SRH services

- *Define interventions for which resources are needed* – modern contraception commodities and services (averting unintended pregnancies); Safe Abortion Services; post abortion care, management of complications etc.
- *Define population in need* (numbers) for each intervention and activity
  a. Couples, adolescents and women for different contraception mix and other FP services
  b. Population in need for safe abortion; for post abortion care; Other SRH activities – list
- *Top down costing* - review current budgets and utilization to estimate resources for SRH
- *Bottom Up costing* - Estimate cost of SRH services by inputs or resources used for interventions/ activities of the program
  - Find direct intervention costs specific to a person receiving the range of services and commodities. For each activity cost can be estimated by using ingredient approach for inputs such as personnel time for service delivery, consumables, medications, diagnostics etc.
  - Commodities costs for different contraceptives- Oral pills; Condoms; Intrauterine devices; Implants; Injectables
  - Indirect program operational and administrative costs – can be estimated by different costing methods - includes supervision, management, training, outreach and advocacy, monitoring and evaluation, transport and communications
  - Unit Costs an be estimated by different providers/facilities or level of service delivery- primary, secondary, tertiary; by users, usage methods (barrier, hormonal, reversible and permanent), activities or inputs
- Assess *commitment* of the government to provide SRH services - Match the intervention categories to budget categories Quantitative projections should be in line with the national goals, commitments and budgets available

Forecast resource requirements and funding gap analysis

1. Based on costs estimated per service rendered or per person covered, project the resource requirement for scaling up SRH services by combining the costing data with demographic data and coverage goals to generate resource required for scaling up services nationally.
2. Forecast of the requirements is made grounded on a review of the Family Planning (FP) and SRH budgetary allocation patterns and expenditure - Estimate the current and future availability of resources from different domestic and international sources.
3. Estimate Gap in resource requirements from 1 and 2.
4. *Estimate* costs for alternative scenarios of interventions– e.g., community focused program vs. clinic focused or comparing costs for case management for 50% vs. 75% of population in need.
5. Estimate how much can government expand given the fiscal space.
6. Estimate how much can be financed from OOP without putting burden on poor and vulnerable.

Cost effectiveness analysis

- Cost-effectiveness analysis (CEA) compares the relative costs and outcomes (effects) of different interventions/ courses of actions – e.g., using different types of family planning commodities or methods.
- Typically, the CEA is expressed in terms of a ratio where the denominator is a gain in health outcomes e.g., years of couple years protection increased; or unwanted pregnancies averted; and the numerator is the cost associated with the activities that are linked to that health gain: in this case the costs of contraceptives.
- CEA for pregnancy related care can be assessed in terms of costs of health services for maternal care including abortion and post abortion care and outcomes can be assessed in terms of maternal deaths averted.

Investing in contraceptives and pregnancy related services is cost effective

- For 132 LMIC countries - $68.8 billion is required annually in 2019 U.S. dollars, or approximately $10.60 per capita (i.e., per total population in LMICs) to meet women's need for modern contraception, pregnancy related maternal and newborn care and treatment of curable STIs
  - Sub-Saharan Africa requires largest boost in resources – an increase from $3.4 to $15.8 per capita annually because of largest unmet needs and poor health systems
  - Direct costs of providing contraceptive commodities for LMIC's for 705 million was $3.5 billion and indirect costs of contraceptive services was $3.6 billion. Cost per user was $5.
  - Every $1 spent on contraceptive services beyond the current level would save $3.26 in pregnancy related and newborn care (which includes safe abortion and post abortion care) because contraception reduces the number of unintended pregnancies.
  - The direct cost of providing pregnancy-related and newborn care at current levels of coverage in LMICs was estimated at $30.3 billion for 2019 with 50% being indirect costs. These prevent 126,000 maternal deaths from 425,000 to 299,000.

Adding it up: Investing in Sexual and reproductive Health 2019, Guttmacher.org

Equity and financial protection

1. Equity in the use of services refers to reducing the gap that exists between the need for a health service and the actual use of that service. Analysis can be by population and geography.
2. Financial protection and equity in finance
    a. Equity in the distribution of resources - Percentage of population covered by different pools of resources
    b. Out of pocket spending share in total SRH spending
    c. Percentage of household's resources in each income quintile that are used for paying for SRH services
    d. Percentage of targeted population facing impoverishment (Targeted Population that fall below the poverty line when spending on SRH services)
    e. Percentage of targeted households facing catastrophic health expenditures, that is household spend more than a threshold (normally 10% of their household's consumption for 40% of households' consumption on food) for SRH services.

Innovations in Financing and Sustainability for Sexual and Reproductive Health

Innovations in SRH Financing

- GOAL – Increased coverage, equity in physical and financial access and use of SRH services and improved quality of services

- 5 Areas to reach these goals
  1. Targeting - Targeted Financing and policy – impacts access and quality of SRH services
  2. Expansion of government services
  3. Subsidy delivery - Demand side financing
  4. Pay for Performance – Supply side financing
  5. Sustainability

What national policies can reduce financial barriers?

- Reduced taxes on FP commodities such as condoms – can reduce prices and improve demand
- Approval for specific drugs – e.g., Misoprostol (as alternative to oxytocin) for post partum hemorrhage (PPH) prevention and treatment. Is easily administrable, stable for long periods to reach the poor - has positive impact on RH of women – Tanzania, India and Nigeria (PPH accounts for 25% of MMR)
- Need central decisions on *what* services to be financed by government, *Where* (rural/urban), *How* (what providers) and to *whom*
  - E.g., FP services that draws most of the OOP can be provided free at government facilities, or subsidized from government funds if utilized in private facilities, or have prepaid (insurance type) schemes where government can pay the premiums for the poor

Innovations in targeting - how financing reaches the disadvantaged

- Sustained accessibility and client-based programmes
  - Avoid barriers to access – distance, opening hours, stockouts, reducing/ abolishing user fees to overcome financial barrier.
  - Better identification of needs through community leaders and grassroot organizations e.g. Colombia health equity fund.
  - Using lower-level providers/ those used by poor for subsidized services (e.g., rural medical informal practitioners in India and Bangladesh or for-profit providers in Peru– franchising the network and financing their training, Supplies, advertising and managing them to provide services at low posted price to the poor).
  - Ensuring that vulnerable are aware and use the government subsidized health services – Counselling through Community based workers in India, Pakistan and Turkey showed positive impact.
  - Ensuring responsiveness and gender sensitiveness by providers at the service sites.

Innovations through strategic purchasing and Public Private Partnership (PPP)

- Contracting NGOs and Faith Based organizations e.g., in Ghana Government provides training, supplies and other support. NGO work as branches of the Government.
- Contracting specific services to private providers – flat rate reimbursements for specific services to poor – e.g., deliveries under Chiranjeevi program in Gujarat, India; FP services in Colombia and SRH services in Malawi. Also in US, UK and Germany.
- Under National Health Insurance schemes contracting private providers and clinic groups e.g., India, Nigeria and Philippines.

Innovations in demand side financing

- Demand side financing to change patient behaviour
  - Through Cash transfers e.g., for institutional deliveries by poor
  - Vouchers for specific products or services e.g., in Kenya and Uganda for RH services and STI treatment;
  - Incentive based vouchers to reduce the costs to recipients e.g., Conditional cash transfers in Mexico
  - Paying a fixed amount for transportation
  - Providing or paying for boarding facilities close to place of service

Supply side financing

- There are different modes of payment for human resources besides global budgets/ salaries such as capitation, case-based payment, per diem which can be linked to performance to improve access to SRH and FP services.
- In Pay for Performance (P4P) or Conditional Cash Transfers (CCT) models, a financial incentive/ rewards are given to service providers for meeting certain performance targets. E.g., Maternal, newborn and child health service volumes increased, and quality of services improved in government health facilities in Bangladesh (Rob et. al. 2013).
- Accredited Social Health Activist (ASHA) are paid under Janani Suraksha Yojna program in India to increase access to ANC services and institutional delivery.

Innovations in sustainability

- Difficult to sustain innovative financing for these low-cost preventative services, where margins are low for private providers - need cross subsidization with other services that are offered by the clinic – e.g., diagnostics, surgeries, etc.
- Community empowerment, service improvement at lower levels, training of human resources and empowering community workers improves awareness and sustainable demand for these highly elastic services.
- Requires understanding of local conditions - how SRH services are financed are important for design and assessment of programs for sustainability. E.g., which are the external financed SRH programs and what specific components are essential to be financed from domestic resources.
- Since these are everlasting life course services, hence advocacy for minimum fixed proportion of national budget for SRH services can play significant role in its financial sustainability.

Resources

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THANK YOU