MARIE STOPES INTERNATIONAL
Children by choice, not chance

Country focus: Ghana

Theme: Financing

Marie Stopes Evidence Brief

Who pays for family planning? Taking a step towards national health insurance coverage

IN BRIEF

Family planning is often forgotten when countries develop their national health insurance systems.

In Ghana, provision was made for "any relevant FP packages" in the 2012 revised National Health Insurance Authority (NHIA) act – but it has never been implemented.

So Marie Stopes Ghana has been running a pilot to demonstrate how it is possible to integrate family planning into the existing National Health Insurance Scheme.

It will run for two years but early results are already shedding light on how best to implement similar approaches in the future.

NHIS

POPULATION COUNCIL
Ideas. Evidence. Impact.

GHANA HEALTH SERVICE
Your Health-Our Concern

THE CHALLENGE

Getting family planning in national health insurance

In Ghana the NHIA is working with GHS and private providers to make services available to the whole population, but FP is not included in the package of services on offer and there is no clarity on how to pay providers to make it available.

Marie Stopes International's experience of financing and delivering family planning services has shown that, for effective provision of family planning to happen, those financing services need to take into account the 4 Ps of:

People (who is included)

Provider (which are financed)

Package (is each FP service addressed?)

Payment (how are services paid for)

WHAT WE DID

Integrating paid family planning

We are gathering valuable lessons on how to integrate family planning into national insurance schemes to test the effective integration of paid family planning services into the primary health care package.

The pilot aims to demonstrate how best to integrate case-based payments into existing systems, with a particular emphasis on long acting reversible contraceptive (LARC) services.

We are gathering valuable lessons on how to integrate family planning into national insurance schemes

During the development phase we wanted to know:

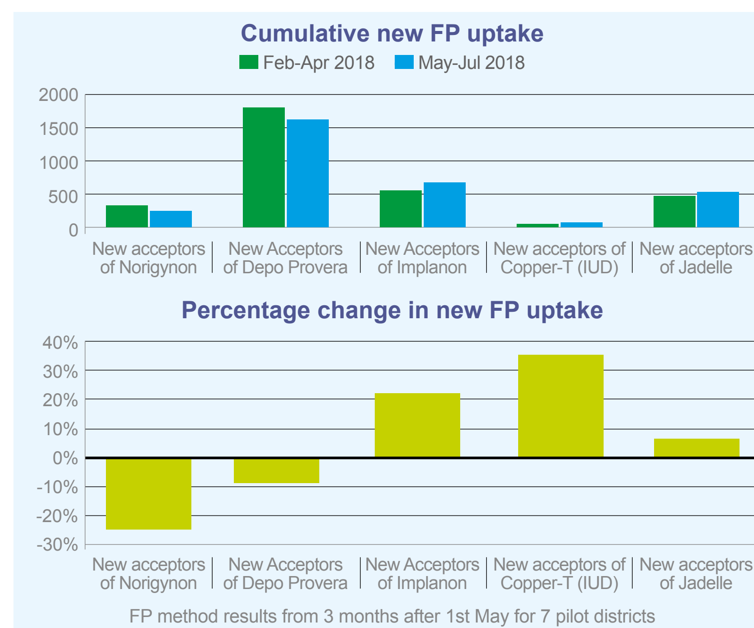
1. Which FP methods should be included in the National Health Insurance package?
2. What should be integrated in the case-based reimbursement tariff?
3. How do we ensure contraceptive commodity security?
4. How do we avoid perverse effects? (e.g. providers leaning towards provision of short term methods for financial gains)
5. How do we ensure contraceptive choice for clients?

Participating public and private providers are reimbursed through the NHIA payment system for each implant, IUD or injectable service provided – including payment for comprehensive FP counselling and provision of the chosen method.

WHAT WE DID

The early results

Although it is too early to address the overarching questions this pilot attempts to answer, a monitoring team made up of NHIA, GHS, Population Council and MSIG has identified some interesting initial findings.The pilot covered all NHIA accredited service providers and payments are made for all contraceptive methods requiring clinical delivery. Participating public and private providers are reimbursed through the NHIA payment systems for each implant, IUD or injectable service provided. After just three months, we've seen a net positive increase in uptake of long term methods. Clients choosing these more effective methods over short-term methods, which have decreased in the same period.



FP method results from 3 months after 1st May for 7 pilot districts

Although 3 months data is very early days yet to make any conclusive inference, it does point to a shift from short acting methods (Norigynon and Depo Provera) to long-acting reversible contraceptives (LARC) – even though the case-based tariffs for injectables serve as an incentive for providers to learn towards its provision. It further supports our assumption that the removal of out-of-pocket cost will shift FP uptake from cheaper but less effective methods (short acting methods) to expensive but more effective methods (LARCs). However, with some of the challenges in the start up it is too early to draw definite conclusions from this.

WHAT THIS MEANS

Where do we go from here?

The FP pilot experienced some initial operational challenges, but there have been enough positives and gained insights that will help shape a national roll-out.

We have seen that you need to have innovative approaches in order to reach the poor with contraceptive services. In addition to the early results described above we've learned some valuable lessons about the 'how' of doing this type of work, such as:

- **Include contraception from the start** – to successfully integrate family planning into a benefits package, the 'how' of including contraception should be thought through very carefully by applying the 4Ps mentioned above at the design stage.
- **Understand stakeholders' views** – to help anticipate potential stakeholders interests and responses and strategise on whether and how to address them.
- **Be patient** – the complexities of family planning, particularly any cultural barriers, are not always understood so a level of learning should be integrated as part of the pilot to inform the national scale up plan.
- **Be flexible** – key elements of a pilot project may not be fully defined upfront; changes will continue to be made as new information comes in.

This pilot still has some time to run before delivering the answers to the questions it set out to address which, we hope, will help shape the NHIA's decision on formally integrating FP into the NHIS package. In the meantime we hope that lessons learned in Ghana can inform similar decisions that are being made as health insurance packages are developed in countries across the region and beyond.

Where can I find more information?

For more information on Marie Stopes International and the work that we do please contact:

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