Reproductive Health and Research

Policy brief

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Financing sexual and reproductive health-care services

This policy brief is intended to give guidance to sexual and reproductive health policy-makers on the critical issues in health-care financing that affect the financial sustainability of sexual and reproductive health services and programmes. It identifies three essential functions of financial policy that need be considered in adapting the WHO Global Reproductive Health Strategy *(1)* at the country level: resource mobilization, resource-pooling, and purchasing of services and commodities.

Health financing systems should help societies achieve their health-care goals. A recent World Health Assembly resolution (WHA 58.33, available at: http://www.who.int/gb/ebwha/pdf_files/WHA58/A58_33-en.pdf) underpins the complexities involved in health financing, and points out that financial policy should be guided by the goal of ensuring that sufficient funds exist for everyone in society to have access to needed health services without risking financial catastrophe. WHO terms this vision *universal coverage*, which comprises three elements: *equity in access, protection against financial risk,* and *equity in financing (2)*. The third element includes the notion that households make financial contributions to the health system on the basis of their ability to pay. This policy brief describes briefly three essential aspects of health financing that need to be considered in adapting the Global Reproductive Health Strategy at the country level: (i) resource mobilization, (ii) resource-pooling, and (iii) purchasing. Although every health system carries out these functions, each system organizes them differently (sometimes even within the same country), reflecting variations in institutional structures, societal expectations and public governance *(3)*.

Resource mobilization

In recent years, thanks to private foundations and major bilateral and global health initiatives, resources for health care at the global level have grown substantially. However, in the area of sexual and reproductive health, these funds are being directed largely towards HIV/AIDS activities, and overall this has resulted in a reduction in external funds available for some aspects of sexual and reproductive health (e.g. family planning) *(4)*. As a result, national sexual and reproductive health policy-makers are facing considerable challenges in negotiating the use of these external funds at the country level to support the full range of sexual and reproductive health services as defined in the Programme of Action of the 1994 International Conference on Population and Development *(5)*.

The situation in many developing countries regarding domestic funding for health care is not encouraging. Governments raise funds for health care through a combination of direct or indirect taxes, health insurance premiums and fees charged for services provided by the public health system. Because of the severe constraints on government revenues in low-income coun-

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tries, little improvement in the amount of funds from these sources for sexual and reproductive health programmes can be anticipated. Non-state-owned, community-based financing schemes (cooperative pooling schemes for health care) are increasingly being tried as a way to supplement government-sponsored health care schemes. These schemes may not cover services that are regarded in some communities as sensitive, such as family planning services, or may exclude some groups, such as unmarried adolescents or the poor. One way to overcome the shortcomings in allocating resources and assigning priority to sexual and reproductive health at the national and subnational levels is to provide evidence on sexual health and reproductive health expenditures *(6)*. Such information can help policy-makers, as well as community groups, to make decisions regarding the allocation of funds for sexual and reproductive health.

Resource-pooling

Pre-payment of health care costs through a resource-pooling scheme is an essential element of "universal coverage". Such a scheme involves advance collection of health-care costs through *tax-based insurance* or *social health insurance* schemes. In both cases the principle is to place the collected revenues in a fund from which health-care costs (for the enrolled population or contributing members) are paid out. Social health insurance schemes normally provide health insurance coverage, only to contributing members. However, in the context of universal coverage a social health insurance scheme pays for the health care of all, regardless of ability to pay the set premium; the government makes a contribution to the scheme on behalf of those who are unable to pay. There are many factors to consider in setting up resource-pooling schemes. Some examples include: whether the scheme is to be managed by private or public sector agents; which formula among various options should be used to determine the level of contribution; what criteria should be applied in enrolling members; and what rules should govern the renewal or continuation of membership. Each of these factors further involves numerous considerations. Therefore, it can take time to make resource-pooling schemes operational – decades in some cases. Establishing pathways for creating pooling mechanisms is a prerequisite to achieving the financial risk protection inherent to universal coverage.

Policy-makers should note that many of the elements of the Global Reproductive Health Strategy can be implemented in resource-poor settings only within the context of resource-pooling schemes *(7)*. For example, the goal of having all births attended by a skilled attendant – who is a professional and therefore provides a paid service – or shifting to facility-based deliveries (for emergency obstetrical care) requires consumers to pay for the maternal health care services.

In developing resource-pooling schemes, two general policy issues are of critical importance for sexual and reproductive health programmes: (i) selection of health-care services that are covered under the scheme (benefits package); and (ii) deciding who can participate in the scheme (enrolment or membership criteria). Insurance schemes cover a pre-defined benefits package composed of the most cost-effective services that meet the needs of the population. Many schemes use cost-effectiveness analyses (CEA) and disability-adjusted life years (DALYs) to identify health conditions to be covered in the benefits package. There is strong evidence to show that these methods undervalue many sexual and reproductive health needs, including maternal care *(8)*. Therefore, it is important that other criteria be included in selecting the benefits package. Also, many schemes exclude services or pharmaceuticals that are not prescribed by a health care provider (such as oral or emergency contraception).

Ensuring gender equity is also an important consideration in developing social health insurance policies. Where entitlement to the social health insurance is linked to a family member's employment, spousal coverage may be abruptly terminated by loss of employment or widowhood. Guaranteeing an extended period of coverage for family members after enrolment has ceased is an important element to include in universal coverage policy and sexual and reproductive health programmes should strongly voice this need.

Purchasing

Once a resource-pooling scheme is set up, it needs to be managed efficiently. Health services may be provided by the government, or the government may purchase them from the private sector (e.g. through "contracting-out" or "contracting-in" arrangements). Usually, a combination of different purchasing modalities are used by health-care systems, depending on the type of care to be provided, the level at which it is to be provided or the setting of the health-care facility. These raise a number of policy issues that affect the implementation of the Global Reproductive Health Strategy.

When governments are entering into arrangements to purchase or provide health-care services, it is important for those responsible for sexual and reproductive health to ensure that all people have equal access to the services based on their needs. If health-care services are being contracted out on a per-capita payment basis, the needs of people with more complicated conditions (such as reproductive cancers) may not be covered within the amount set. Moreover, sensitive areas of reproductive health care (such as abortion or the needs of adolescents) may be neglected. These policy issues are similar to making decisions on the selection of the range of services to be covered through a health insurance benefits package, and should be

pursued by sexual and reproductive health programmes with vigour.

Another important policy issue in the purchasing of health care by government concerns how payments are made. How staff are paid is an important determinant of the quality and quantity of health-care services they provide. When health services are purchased on the basis of performance-based payment criteria (i.e. number of patients treated for specific conditions), programme managers must ensure that such an arrangement reflects national sexual and reproductive health goals (e.g. the goal of having all births attended by a skilled attendant and provision of services to adolescents). Such decisions may be taken at the highest levels of government for a broad package of services. In such cases, success of a sexual and reproductive health programme may depend on the ability of sexual and reproductive health policy-makers to be able to influence policy decisions in favour of essential, broad-ranging sexual and reproductive health care.

Purchasing arrangements can also be made from the side of the consumer *(9)*. These "demand-side" arrangements give individuals the decision-making power by providing them with credits to use with the provider of their choice. For example, sex workers in a country were given vouchers for STI services, which could be used at any clinic for medical intervention. Owing to the sensitive nature of sexual and reproductive health, several innovative "demand-side" models of purchasing services have been developed in this area.

Conclusion

The provision of a comprehensive sexual and reproductive health programme requires a functioning health system and effective delivery of an integrated package of services as outlined in the Programme of Action of the 1994 International Conference on Population and Development (ICPD). Because this package involves a wide variety of services for a broad range of people in society and includes services that some regard as sensitive, sexual and reproductive health care requires special consideration in policy formulation, especially as it relates to health financing. To ensure universal coverage for sexual and reproductive health, policy-makers need to be informed about health financing policy options available to them.

References

1. *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. Geneva, World Health Organization, 2004 (Document No. WHO/RHR/04.8).

2. Murray CJM, Evans DB. Health systems performance assessment: goals, framework and overview. In: Murray CJM, Evans DB, eds. *Health systems performance assessment: debates, methods and empiricism*. Geneva, World Health Organization, 2003 (pages 3–18).

3. *Health sector reform and reproductive health. Report of a technical consultation meeting, 30 November–2 December, 2004*. Geneva, World Health Organization, 2005. Available at: http://www.who.int/reproductivehealth/tcc/meeting.html (accessed on 24 April 2006). This report formed the basis for this brief.

4. *Trends in ICPD categories*. The Resource Flows project. Available at: http://www.resourceflows.org/index.php/articles/c78 – accessed on 24 April 2006.

5. *Programme of Action of the International Conference on Population and Development*. New York, NY, United Nations, 1994 (paragraph 7.3). Available at: www.unfpa.org/icpd/icpd_poa.htm (accessed on 24 April 2006).

6. *Guide to producing national health accounts with special applications for low-income and middle-income countries*. Geneva, World Health Organization, 2003.

7. *The world health report 2005: make every mother and child count*. Geneva, World Health Organization, 2005 (pages 137–139).

8. Alvarez-Castillo F. et al. Priority setting. In Sundari Ravindran TK, de Pinho H, eds. *The right reforms? Health sector reforms and sexual and reproductive health*. Johannesburg, Women's Health Project, School of Public Health, University of Witwatersrand, 2005.

9. *World development report 2004: making services work for poor people*. Oxford, Oxford University Press for the World Bank, 2003.

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