Integrating Family Planning with Primary Health Care

Approaches & Lessons

March 28, 2019

Webinar

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RESULTS FOR DEVELOPMENT

Today's cast

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Speakers

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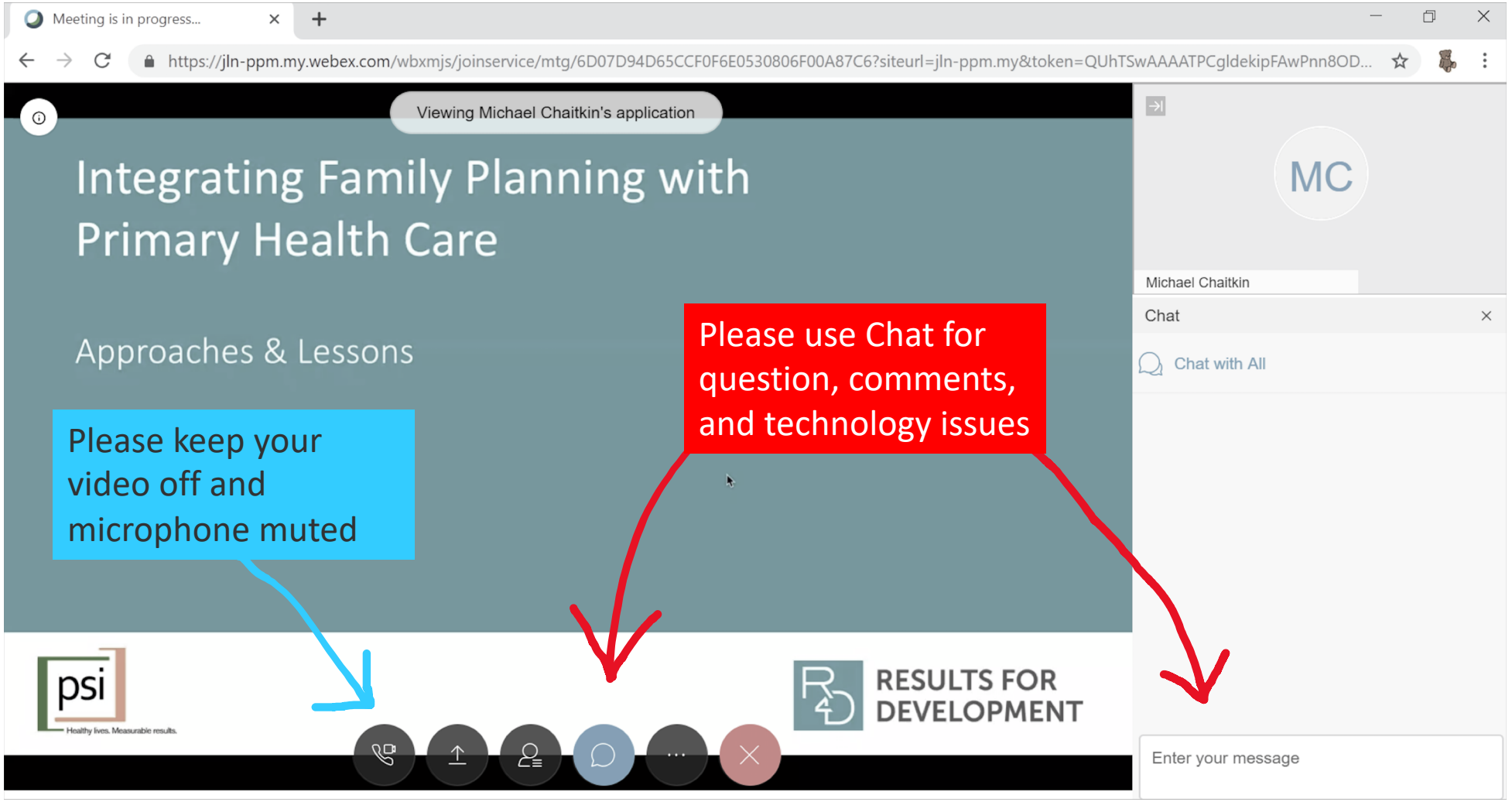
Chat and Audio/Visual Controls



Defining, analyzing, and deciding about integration of vertical programs

Michael Chaitkin
Senior Program Officer
Results for Development

Full author team: Michael Chaitkin, Nathan Blanchet, Yanfang Su, Rebecca Husband, Pierre Moon, Andrea Rowan, Steve Gesuale, Candice Hwang, Paul Wilson, and Kim Longfield

Intuitively, integration seems like a great idea…

Access Convenience Responsiveness Equity

Quality Continuity Coordination Morale Oversight

Efficiency Economies of scale and scope Consolidation

…but there may be reasons for caution or resistance

Understanding integration for vertical programs

What stakeholders say:

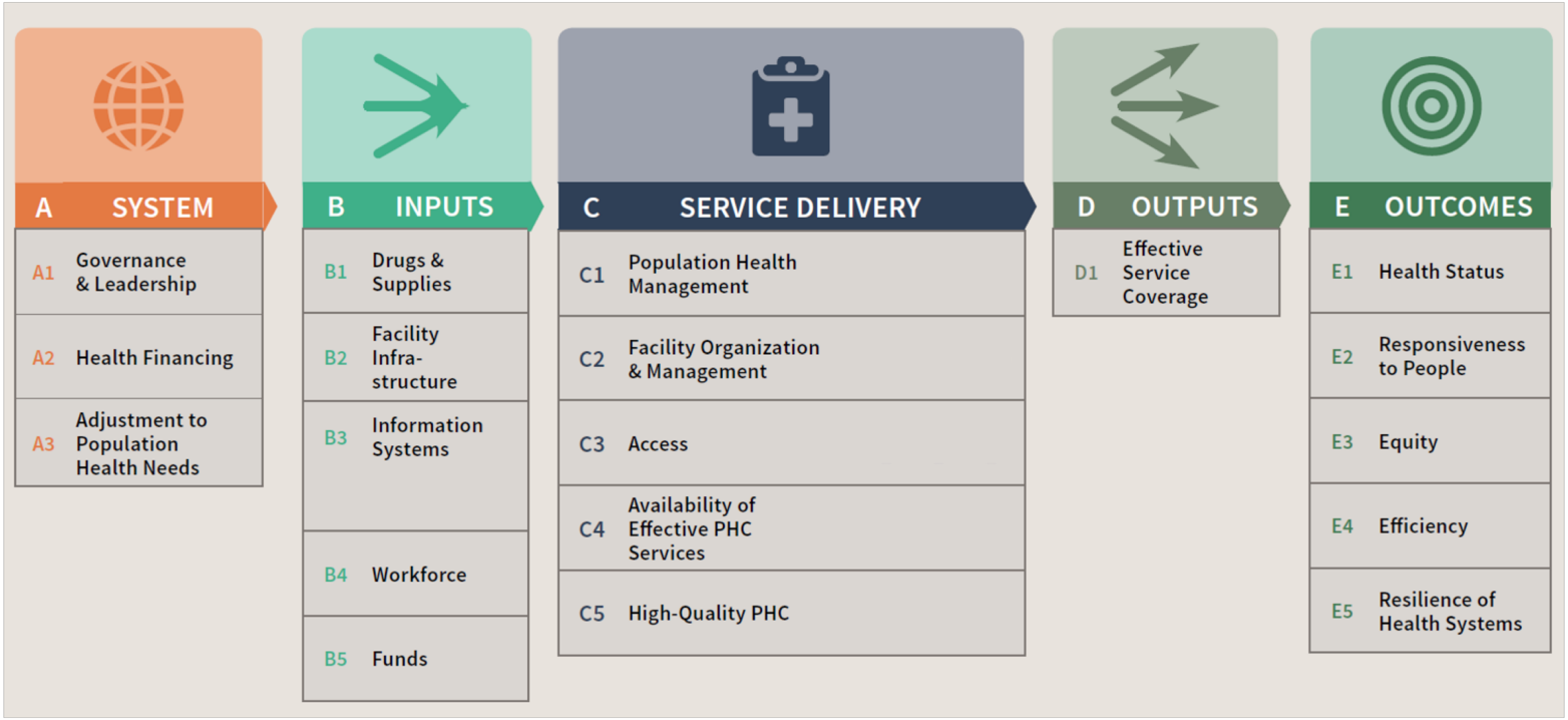
"[Integration is] when an individual goes to a health facility and is able to do everything at that facility on the same day, rather than having to come back on separate days."

– Malawi

What the evidence shows:

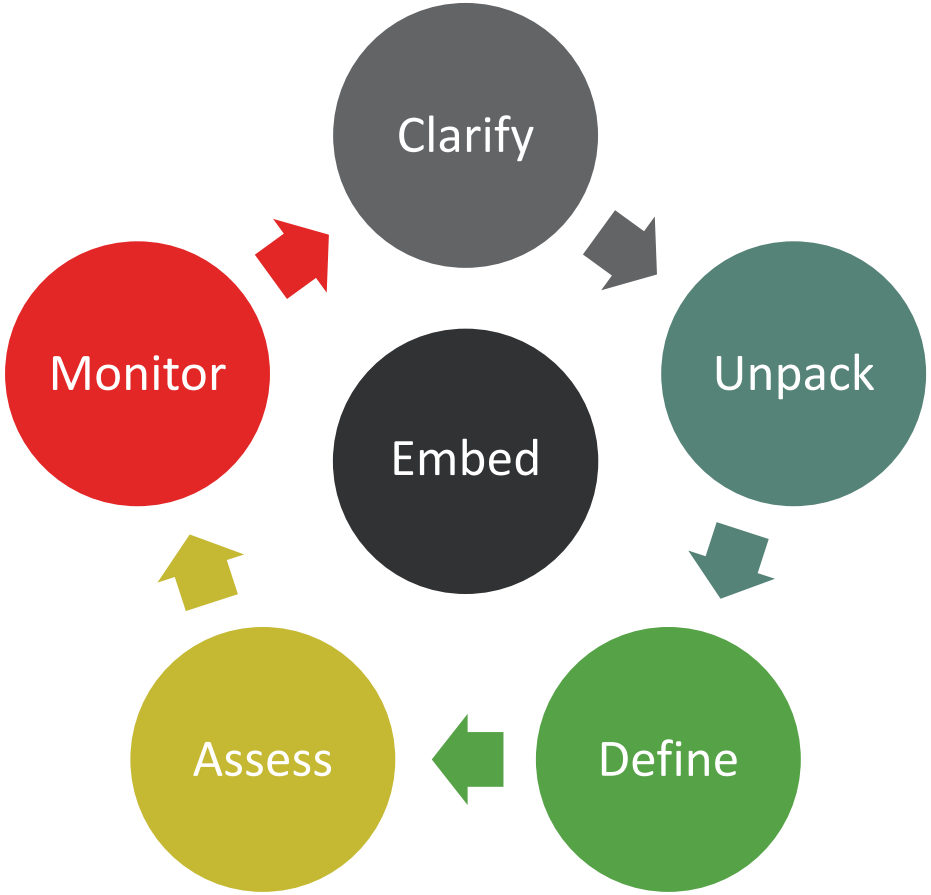
- Integration studies focus mainly on the service delivery environment
- Broader health system strengths and weaknesses matter a lot
- Benefits are clearest from integrating natural service combinations
- Some examples of worse outcomes after integration

Integration is about changing the relationship between the program and the rest of the health system



Graphic source: English, Allyson, Chloe Lanzara, Arunima Awale, and Laurel Hatt. 2018. Measuring What Matters: Case Studies on Data Innovations for Strengthening Primary Health Care. Primary Health Care Performance Initiative. Primary Health Care Performance Initiative.

Decision-making requires more than analysis



Integration requires a blend of consultative and analytic steps

1. Embed in routine health planning process
2. Clarify the objectives
3. Unpack the status quo
4. Define integration options
5. Inclusively assess and select options
6. Monitor progress and identify areas for incremental improvement

Looking for more details?

Blog

Should vertical programs be integrated into primary health care?

Michael Chaitkin, Rebecca Husband, Kim Longfield | March 21, 2019 | Comments

PRIMARY HEALTH CARE

By Michael Chaitkin, Rebecca Husband (of PSI) and Kim Longfield (of Databoom)

At the 2018 Global Conference on Primary Health Care, world leaders affirmed that primary health care is central to achieving universal health coverage (UHC). This renewed commitment coincides with stagnating donor funding for health, which for decades has supported programs dedicated to certain diseases and health needs.

These "vertical" programs have contributed to tremendous gains, but countries cannot indefinitely afford separate responses to each health need. And even the most successful vertical programs are finding limits to what can be achieved without better leveraging the broader system.

Technical Report & Ghana and Malawi Case Studies

What to remember

1. Successful integration is about more than service delivery
2. Integration is neither all-or-nothing nor all-at-once
3. Better analysis should feed into country-driven decision-making processes about whether, when, and how to integrate

Panel discussion

Jayne Rowan
Deputy Director for Health Markets
Marie Stopes International

Integration context in Ghana

- Why has it taken so long to implement integration, and what provides the impetus now to overcome obstacles?
- To what extent was family planning already integrated with PHC, and which components of family planning stood partially or fully apart?

The NHIS and contraception: Key facts

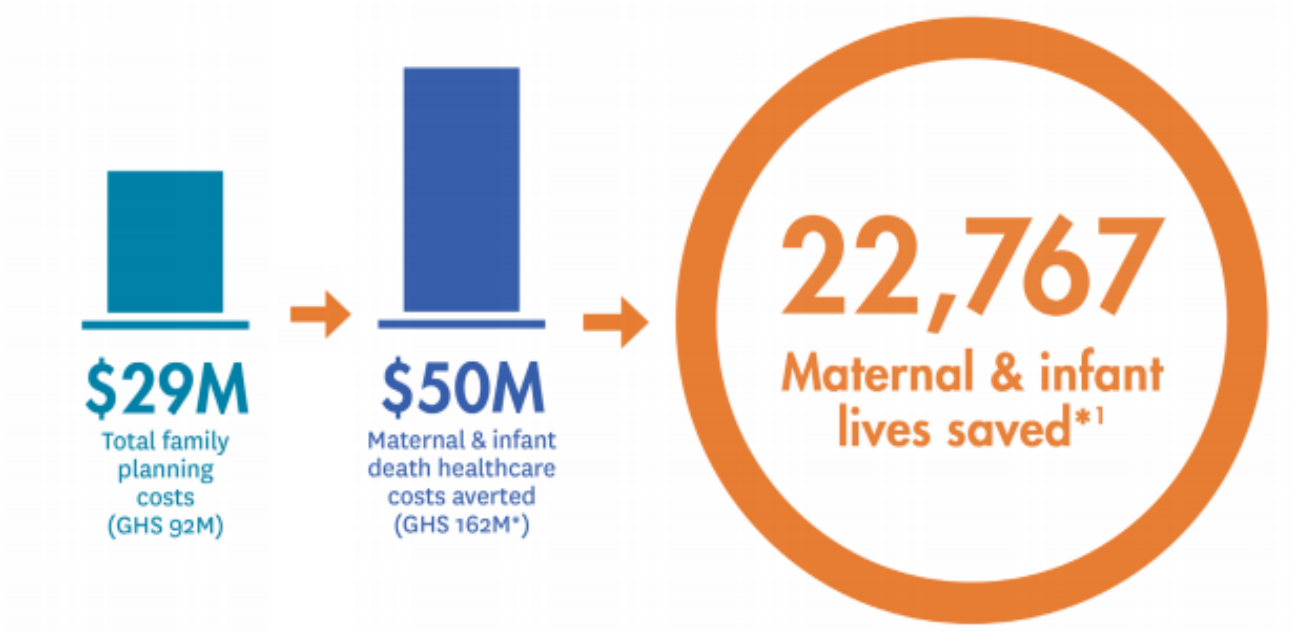
- The NHIS was established by an Act of Parliament in **2003** to secure financial risk protection from cost of healthcare services.
- The benefits package is exceptionally comprehensive but **contraception was excluded from the original design**.
- **Free maternity services** were added for all pregnant women in 2008 – contraception was still excluded.
- The Act was revised in 2012 – NHIS Act 852, and **included full coverage of family planning** services in its list of benefits.
- Implementation of the 2012 Act has stalled and **contraception services remain out-of-pocket** in public and private facilities across Ghana to the present, except tubal ligations which is covered by in-patient.

NHIA cautious about financial implications of FP inclusion and sustainability (given NHIA financing issues)

The NHIS and contraception: Key arguments

Significant policy work and evidence gathering has been done to push for contraception to be included in NHIS since 2003. **Researchers demonstrated that including contraception in the NHIS package would save lives of mothers and infants and also create direct savings in healthcare related costs** especially relating to maternity services in **all four investment scenarios** that they modelled.

Costs and Lives Saved from 2014–2020 with 'Moderate' Family Planning Investment



Government Declarations Declarations

- Sustainable Development Goals – Universal Health Coverage
- FP 2020
- Ghana Beyond Aid

Operating Environment

- Capitation piloted
- Service package costing

MSI suggested FP pilot to move the discussion from theory to effective implementation

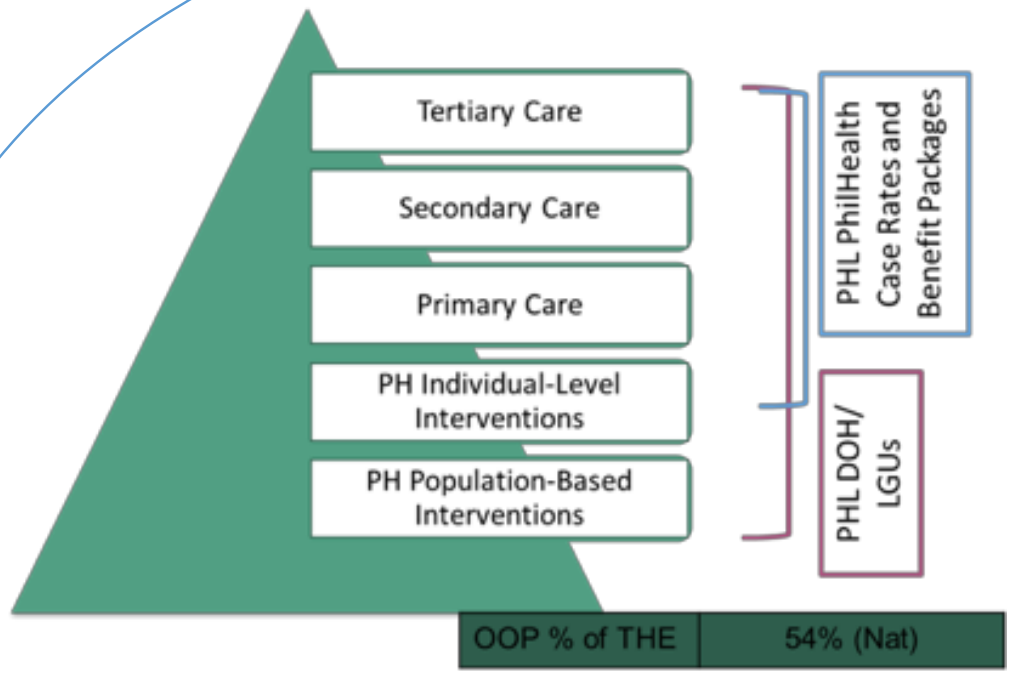
Source – Chaitkin, M., M. Schnure, D. Dickerson, and S. Alkenbrack. 2015. How Ghana Can Save Lives and Money: The Benefits of Financing Family Planning through National Health Insurance. Washington, DC: Futures Group, Health Policy Project.

Dr Pura Angela Wee Co
Health System Specialist
ThinkWell

Integration context in the Philippines

- How is the impetus similar or different for the Philippines to sort out integrating family planning into PhilHealth coverage?
- Who is championing this agenda within government and beyond?

Financing for Family Planning in the Philippines



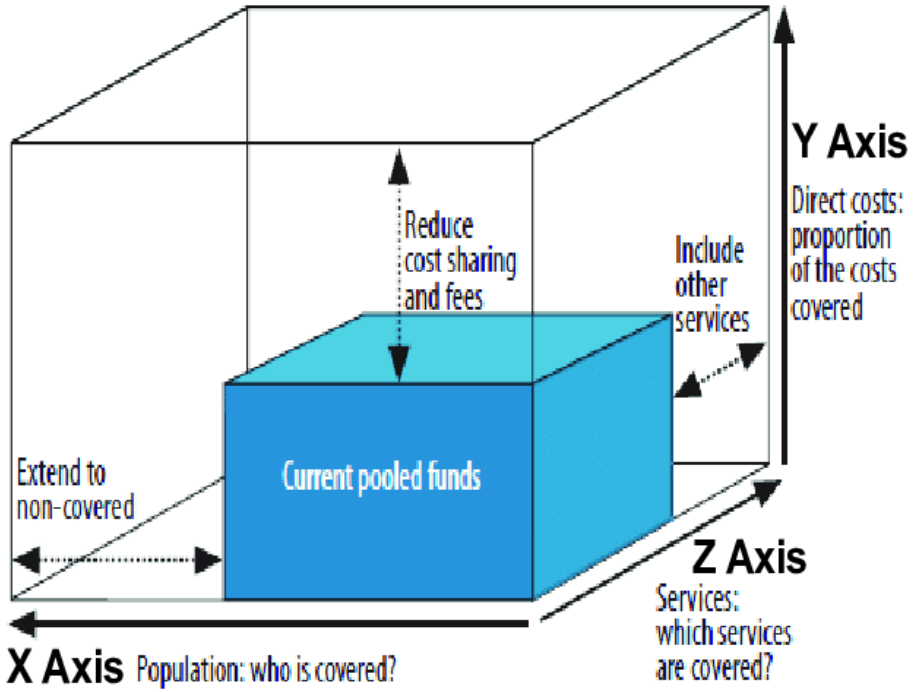
- IUD
- Vasectomy
- BTL
- Subdermal Implant (2015)

TRO for the RH Bill

Poor access to commodities

Lack of trained HHR

Universal Healthcare Law



- Increased coverage
  - Simplification of membership
- Improve service and cost coverage
  - Comprehensive Primary Care
- Improve accountability
  - DOH for population based services
  - PhilHealth for individual based services
- Reforms for HHR, Access to Commodities

Sylvia Wamuhu
Director of Franchise & Partnership
Population Services Kenya

Integration context in Kenya

- Why did PS Kenya choose a social enterprise model as a response to government's call for UHC?
- How does the new model work, and how does it bring together socially franchised providers to delivery PHC services in a more integrated fashion?

Kenya's private sector is key to achieving UHC

UHC Vision: By 2021, all Kenyans will have access to essential services without the risk of financial catastrophe

- >51% of health facilities are private
- Private sector provides outpatient and inpatient services to 42% and 44% of the total population
- 19% of Kenyans have Health Insurance: NHIF (88%); Private Insurance (12%)

Private Sector Challenges in Kenya

Fragmented and unregulated

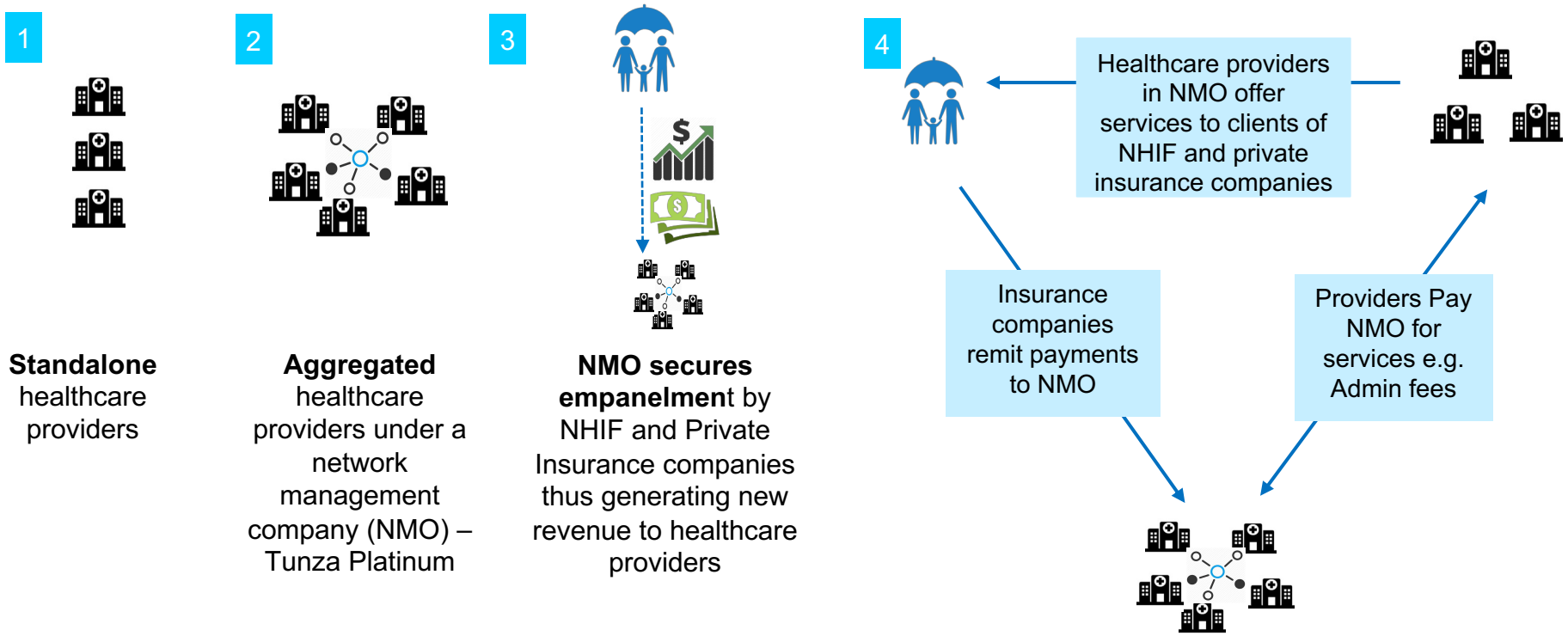
Offers limited health services

- Low quality and unstandardized health services
- Limited access to health services
- Small privates facilities not attractive to insurance companies for empanelment
- Low bargaining power hindering business growth

What does the Tunza Platinum model look like?

The Model

Win-win business case:
- **Payers** access a large network with controlled pricing, low admin costs and high quality health services
- **Health care providers** attract a new revenue stream (patient paying via insurance) to complement their cash (out-of-pocket) revenues
- **Community**: reduced OOPs, increased access to standardized quality services by credentialled providers



Standalone healthcare providers

Aggregated healthcare providers under a network management company (NMO) – Tunza Platinum

NMO secures empanelment by NHIF and Private Insurance companies thus generating new revenue to healthcare providers

Tunza Platinum – Value propositions for a fee

Admin fee, shared discounts, mark ups, membership fees, transactional costs, investment in infrastructure…

Pillar 1: Improved Business Systems

- Tunza Clinic Management System (CMS/EMR/ERP):
- IT support
- Built-in HMIS forms
- Linkage to DHIS2
- Business support
- Access to financing

Pillar 2: Quality Assurance

- Quality assessments (HNQIS & KQMH /SafeCare)
- Quality improvement planning (QIP)
- Quality audit
- On the job training
- Expansion to new health areas

Pillar 5: Aggregation

- Facility empanelment
- Claims management, fraud reduction and reduction in rejected claims
- A pool of ready facilities offering high quality services .
- Wide geographical distribution of empanelled facilities
- Development of micro-insurance products

Pillar 4: Affordable Quality Products and Equipment

- Discounts on drugs, consumables, and equipment
- Pooled procurement
- Inventory management best practices

Pillar 3: Increased Demand

- Tunza Platinum branding
- Capacity building in clinic initiated marketing strategies
- Electronic e-referral system (Connecting with Sara)

Sylvia Wamuhu
Director of Franchise & Partnership
Population Services Kenya

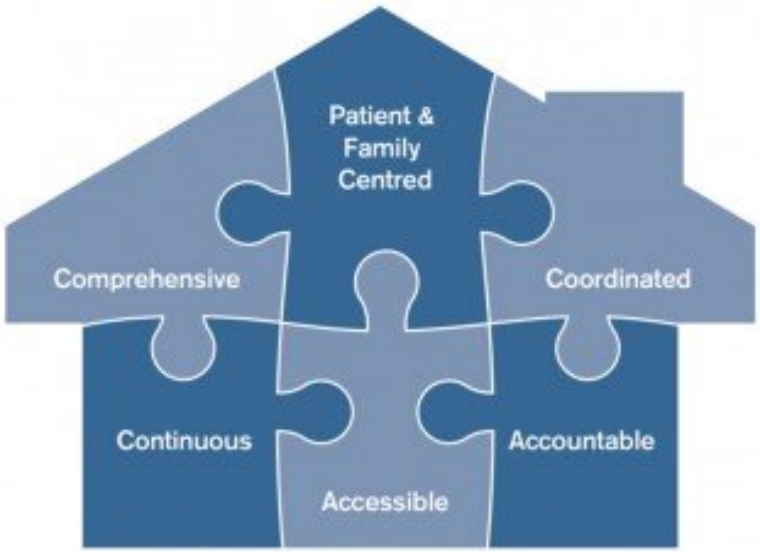
Integration design in Kenya

- Why did PS Kenya decide to integrate and consolidate functions such as quality assurance?
- How have changes to the operational model affected access to PHC and provider efficiency?

Why did PS Kenya decide to integrate and consolidate functions such as quality assurance?

- Changing consumer needs; efficiencies; increased access to PHC; affordability of PHC
- Facility level:
  - Scope of services: from 1 to 8 health areas
  - Quality assurance: HNQIS, SafeCare, NHIF
  - Business support program
- Community level
  - Integration of demand creation activities
    - FP + Cervical + Safe motherhood
    - Safe mother + NHIF
    - FP + HHA+ NHIF+ Cervical cancer

How have changes to the operational model affected access to PHC and provider efficiency?



One-stop-shop for high quality PHC services

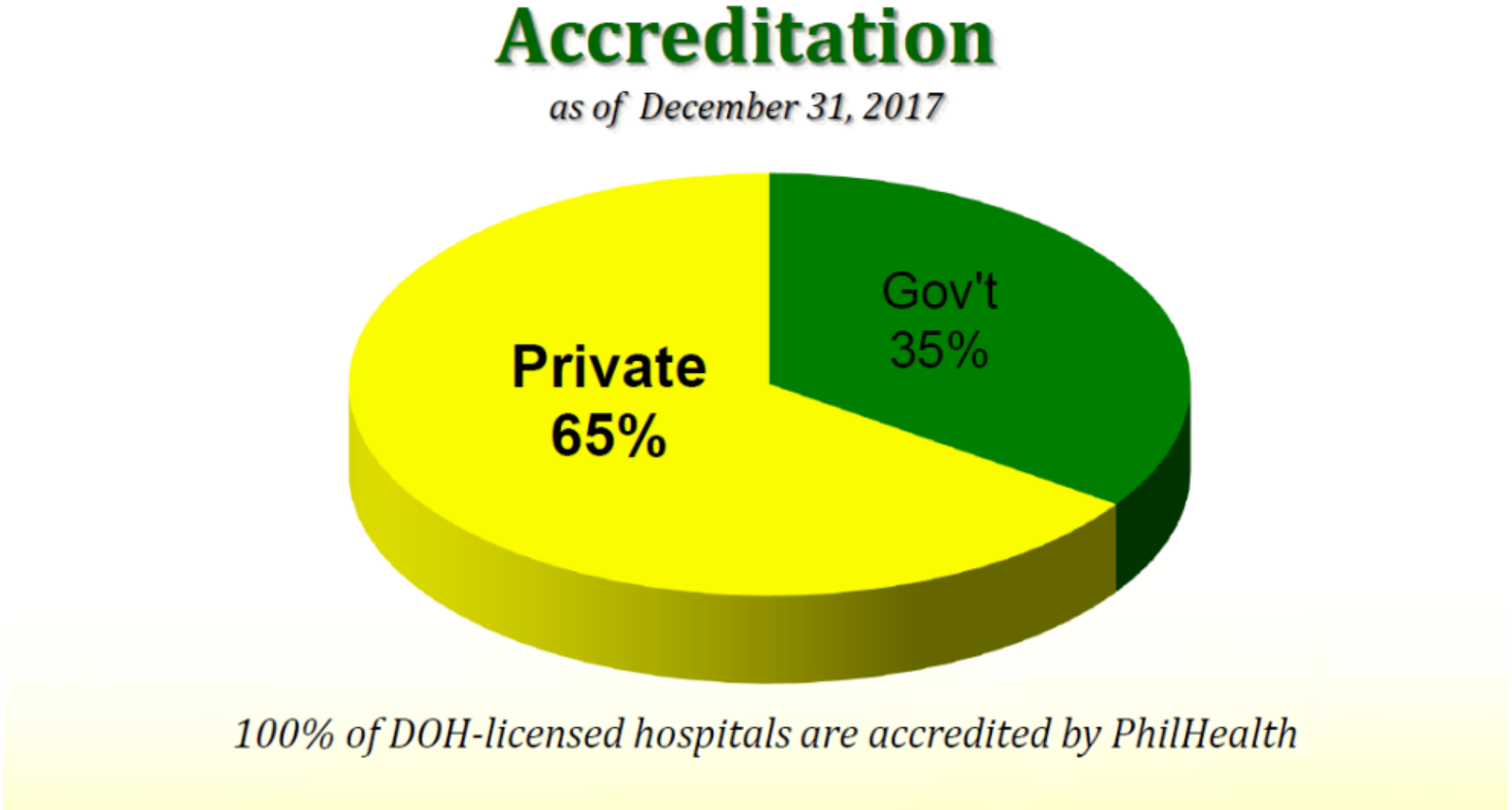
- Increased scope of services
- Increased access to quality and affordable services (NHIF) – Linda Mama, Supacover
- Reduced costs on franchise costs (# of QAOs, better coordination of activities
- Business support – business growth leading to improved quality services (e.g. better equipment)
- Higher reach with health messages

Dr Pura Angela Co
Health System Specialist
ThinkWell

Integration design in the Philippines

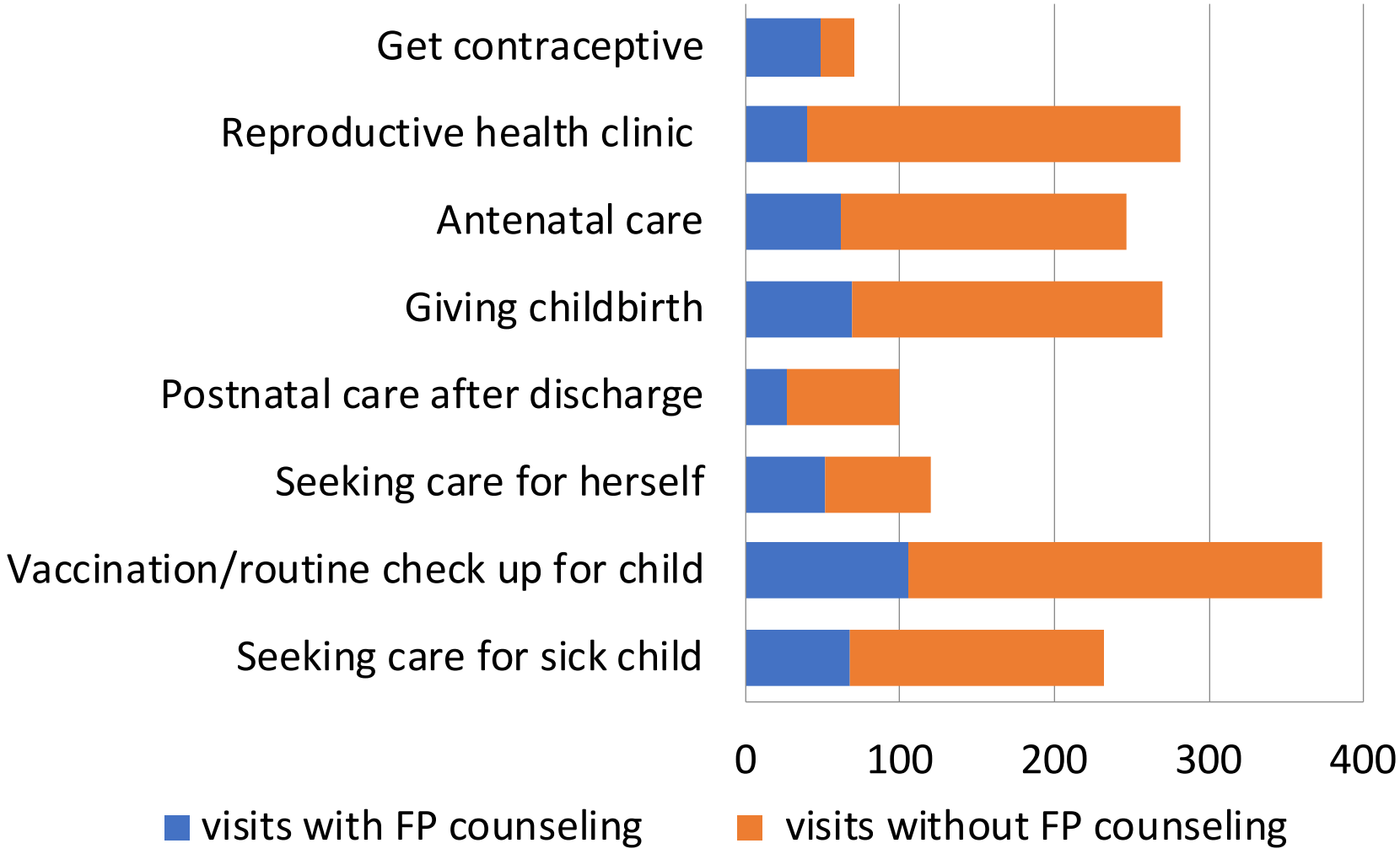
- How will the relationship between PhilHealth and the private sector need to change to meet the country's FP and other objectives?
- Beyond the purchasing contract, what health system issues require attention to realize this vision?

PhilHealth and Private Sector



Reference: PhilHealth 2017 Stats and Chart <https://www.philhealth.gov.ph/about_us/statsncharts/snc2017.pdf>

Missed opportunities during 1,699 visits in past year



Source: Sobel, H. (2018). *Underlying causes of unmet need in Philippines.* Presentation, Manila

Jayne Rowan
Deputy Director for Health Markets
Marie Stopes International

Integration design in Ghana

- For the AHME-supported pilots, how were decisions made on the standard of care to be integrated (e.g., which methods to cover, which to exclude)?
- Were there any components of FP programs thought to be better addressed in an unintegrated fashion?

What would effective inclusion of contraception services look like under NHIS? 4Ps are needed

People

NHIS coverage would be equitable; designed for high-priority groups such as the poor, vulnerable, adolescents and rural populations. NHIS members would also know the benefits of services they are entitled to and how to access them appropriately

Package

NHIS benefits package would explicitly include choice of contraceptive methods, including short-term, long-term reversible, and permanent methods

Provider

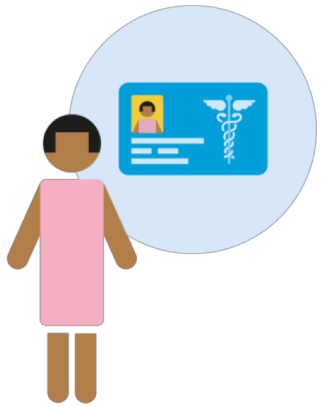
NHIS would accredit community-embedded, smaller facilities well-suited to the service offer (i.e. outpatient providers, midwives)

Payment

NHIA's selected payment approach - including differential case-based payments for long-term methods – would mitigate provider bias to achieve genuine choice

Source: Mazzilli, C; Appleford, G; Boxshall, M: "MSI's health financing assessments 2012-2015: What did we learn about UHC financing and contraception? Four 'Ps' matter. An external findings and discussion paper." Marie Stopes International, London. July, 2016

Aligning 4Ps – the pilot model



People

- Expand IPC to include information about the NHIS pilot contraception benefits
- Those with valid NHIS card eligible for free services
- Those without NHIS card to be charged agreed tariff rate (out of pocket)

Package

- All clinical methods (1+3 month injectable, implants, IUD, vasectomy and BTL)
- Ghana Health Service to provide all commodities to all facilities

Providers

- Accredited NHIS facilities, public and private in 7 districts (145 facilities),
- 2 control districts (48 facilities)

Payment

- Case based tariff (counselling time, consumable costs and overhead costs into case based tariff)
- Facilities will not claim the cost of FP commodities, only services
- Tariff varies by provider type

Jayne Rowan
Deputy Director for Health Markets
Marie Stopes International

Integration lessons in Ghana

- Across the main components and functions of the health system, what have been the main enablers of and obstacles to integration?
- What comes next in the policy design and implementation process?

Integration enablers and barriers

Enablers

1. Strong commitment from stakeholders
2. Design that is flexible to adapt to varying needs
3. Pilot being implemented in both public and private sectors
4. Qualitative research (Population Council)
5. Donor support to fund initiative

Barriers

1. NHIA not issuing new insurance cards
2. Provider capacity to provide LARCs
3. Verifying NHI cards at public sector facilities requires women to present at OPD, and state they are there for family planning. Privacy and confidentiality issues.
4. Limited demand creation activities conducted by NHIA

Next steps for implementation

1. Pilot implementation (to April 2020)

- Introduction of RS Log (provider MIS system)
- Awareness raising and demand creation of FP on NHIS
- Training of providers in LARC
- Mobile authentication of insured
- Strengthening commodity distribution and availability

2. Monitoring of data

- Uptake and experience of choice
- Numbers of participating providers and quality of FP services
- Costs

Pilot evaluation and dissemination

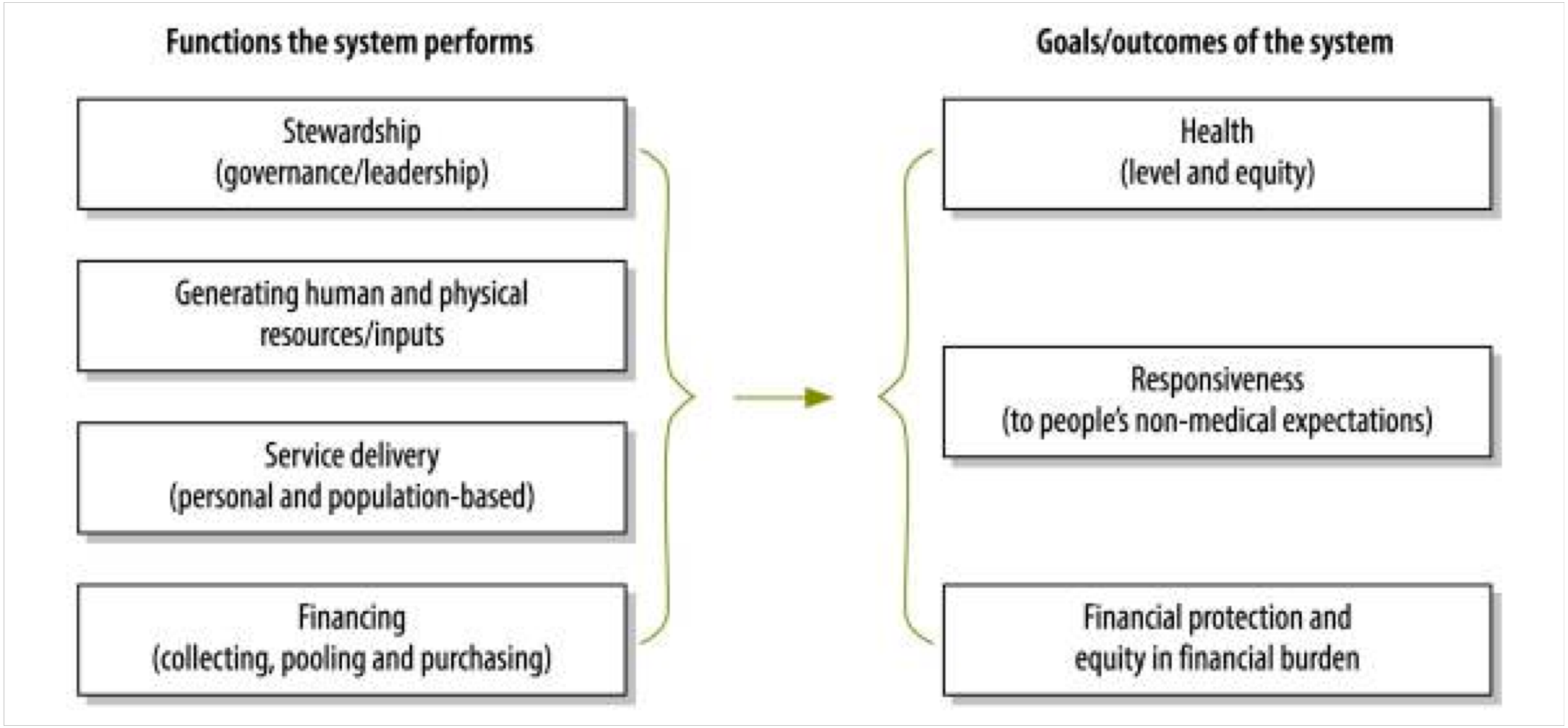
1. Evaluation of 4Ps effects on choice, uptake, quality
2. Assessment and modelling of costs and costs averted (actuarial model)
3. Qualitative assessment of embedded pilot approach (Population Council)

Dr Pura Angela Co
Health System Specialist
ThinkWell

Integration lessons in the Philippines

- What links between purchasing and other health system functions get overlooked in integration discussions?
- And what are some issues for which purchasing *isn't* the right or primary lever to achieve policy goals?

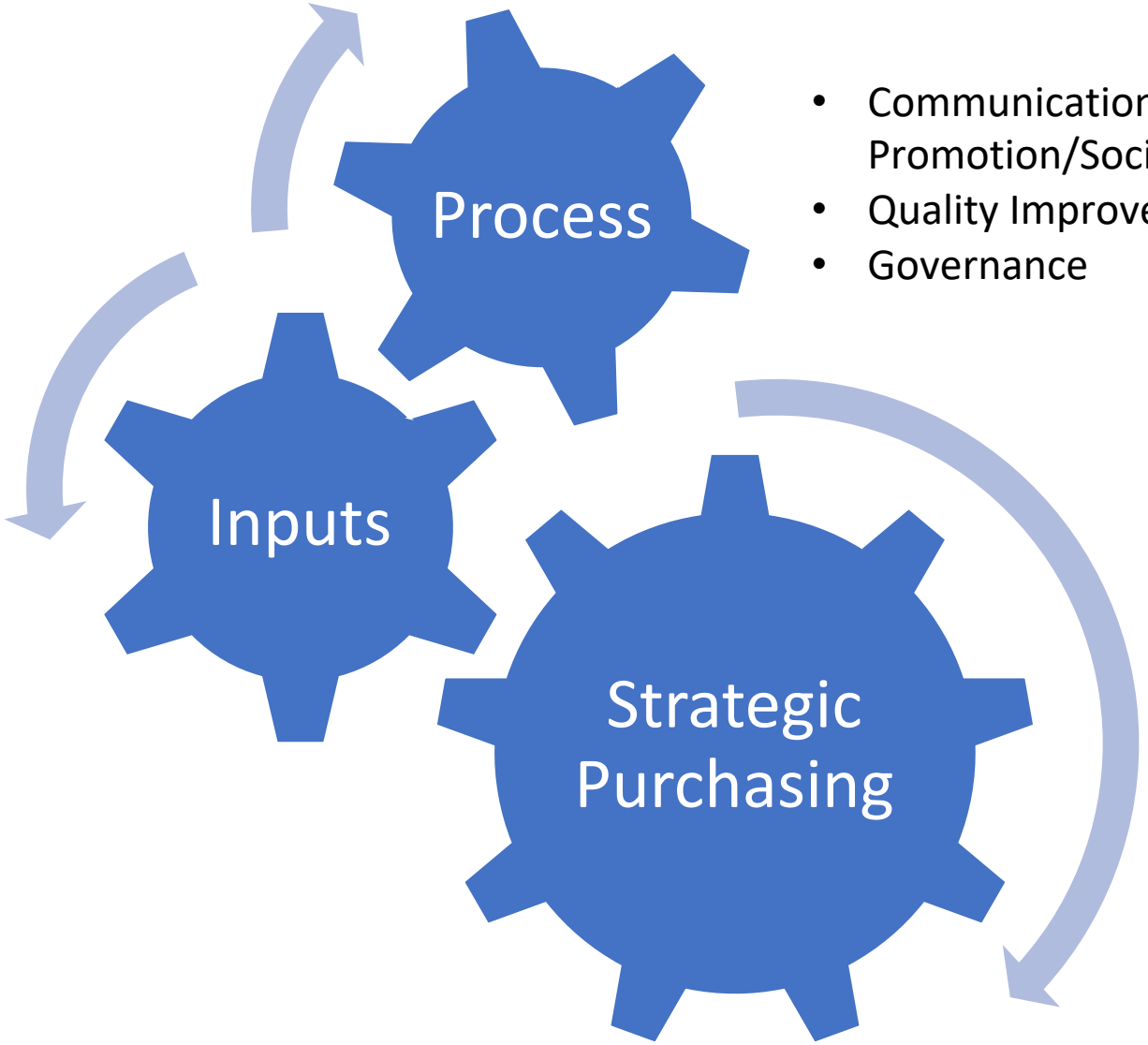
What links between purchasing and other health system functions tend to get overlooked?



Source: Kutzin, J., (2013), Health financing for universal coverage and health system performance: concepts and implications for policy, WHO Bulletin.

Purchasing should be used in an integrated manner with other tools/levers of the health system!

- Medicines
  - Regulation (FDA)
  - Formulary (DOH)
- Facilities
  - Licensing
- Health Human Resource
  - Training/Retraining
  - Licensing



- Communication (Health Promotion/Social Norms)
- Quality Improvement Mechanisms
- Governance

Sylvia Wamuhu
Director of Franchise & Partnership
Population Services Kenya

Integration lessons in Kenya

- What are some challenges PS Kenya didn’t anticipate when you started, and how are you pivoting?
- How can service delivery organizations help make sure FP doesn’t get lost as countries move towards more integrated service packages?

What are some challenges PS Kenya didn't anticipate when you started, and how are you pivoting?

Challenges

1. Time consuming for the QAOs and Demand Creation Team
2. Riding programs (demand creation) sometimes not adequately covered
3. Different health areas do not always suit the targeted population, e.g. NHIF messages best for men who will not attend FP sessions
4. Message uptake by providers can be compromised

Solutions

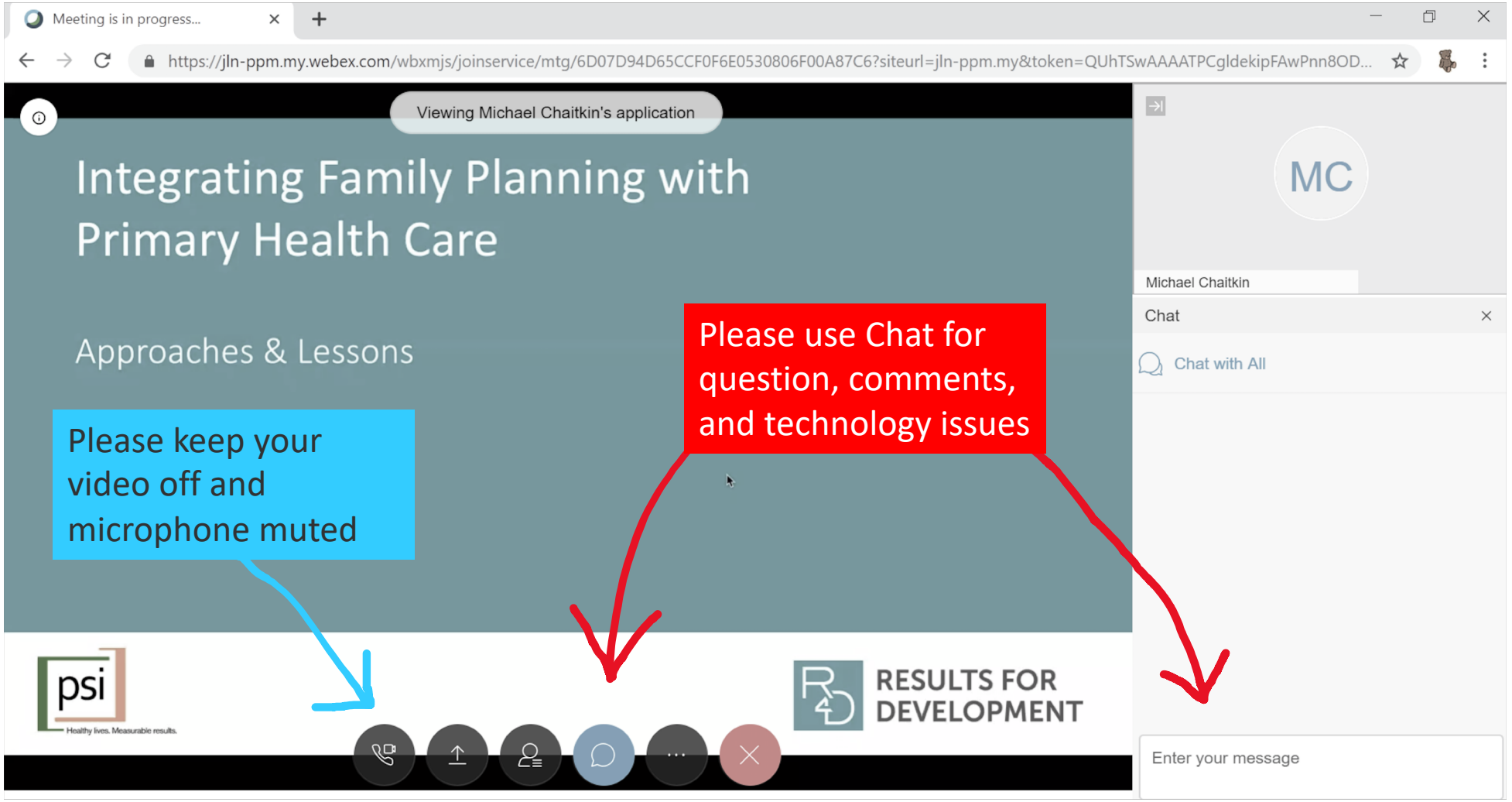
1. Bundling of FP with other health services, e.g. cervical cancer and FP
2. Cross-selling of services, e.g. target PNC mothers, immunization days
3. Integration of FP services at community level, e.g. with ANC
4. Provider education and initiatives, e.g. FP immediately after birth

How can service delivery organizations help make sure FP doesn't get lost as countries move towards more integrated service packages?

- Help strengthen FP policies at national and county level
- Leverage FP as a priority for national and county governments
  - Allocation of resources to FP interventions by counties
  - Commodity security
  - Improved health systems
  - Strong FP champions
- Cover FP under NHIF / UHC packages

Audience Q&A

Reminder: use Chat for questions and comments



Audience Q&A

Closing

Don’t forget to check out these new publications

Blog

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PRIMARY HEALTH CARE

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Technical Report & Ghana and Malawi Case Studies

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Integrating Vertical Programs into Primary Health Care: A Decision-Making Approach for Policymakers

DOWNLOAD THE SUMMARY REPORT

DOWNLOAD THE GHANA CASE STUDY

DOWNLOAD THE MALAWI CASE STUDY

The universal health coverage movement has strengthened advocacy for integration in service delivery and its enabling systems and inputs, particularly following the 2018 Global Conference on Primary Health Care, which marked the 40th anniversary of the Alma Ata Declaration. Many see integration as a way to ensure equitable financing for and access to a range of services, not just those offered by a handful of privileged programs. Countries are also increasingly cognizant of resource constraints and are eager to increase health system efficiency, including through integration.

Authors

Michael Chaitkin, Nathan Blanchet, Yanfang Su, Rebecca Husband, Pierre Moon, Andrea Rowan, Steve Gesuale, Candice Hwang, Paul Wilson, Kim Longfield

Thank you!