How-to of Health Benefits:
Options and Experiences on the Path to UHC in Low- and Middle-Income Countries

or

What services should health systems provide?
Health benefits plans in low- and middle-income countries

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Prospectus for a book and web resource in support of the International Decision Support Initiative (IDSI) led by NICE International[1]

Introduction and motivation

Health benefits plans (HBP) are a policy instrument used to set priorities for public spending on health.[2] Velasco-Garrido et al. (2006) define HBP[3] as a description of "services, activities and goodsreimbursed or directly provided by publicly funded statutory/mandatory insurance schemes or by national health services." At core, benefits plans describe not only "what" is to be provided but also "to whom" and "in what circumstances"[i], and should therefore be at the core of all publicly funded health care, and ultimately progress towards universal health coverage (UHC). And ideally a HBP is not merely a list or a set of decisions, but should also be understood as an on-going process that shapes resource allocation and its outcomes now and in the future ("how 'who gets what' is decided"). Therefore, a benefit plan also defines a specific list of contingent liabilities for its beneficiaries – and consequently contributes substantially to defining its costs as well.

Although readily defined, identifying and classifying HBP in practice is not straightforward, and analysts may disagree on what might qualify. Within the group of health systems that describe the services, activities and goods reimbursed and/or directly provided with some detail, explicit HBP come in many shapes and sizes. HBP may be positive or negative lists, catalogues or fee/reimbursement schedules. They may have broad or narrow scopes in terms of types of technologies, disease control priorities or eligible populations. And HBP may be detailed and granular, or provide a less specific overview or guidance on the nature and content of goods and services to be funded and provided. In this effort, we include a range of what might be considered HBP, from essential medicines lists to micro-packages of MCH services to more comprehensive efforts to define interventions.

Motivations to adopt HBP vary.[ii] The World Development Report 1993[iii], the Commission on Macroeconomics and Health[iv], and –most recently- the Global Health 2035 Commission[v] argue that HBP can

[1] With funding from the Bill & Melinda Gates Foundation, the UK Department for International Development and the Rockefeller Foundation.
[2] We recognize that there are many other micro/macro/meso strategies for explicit priority-setting, but in this product, we focus on one kind: health benefits plans.
[3] Garrido-Velasco et al. use the term "basket" of benefits rather than health benefits plans, but we will use the latter terminology as it is more in use in the field.

be successfully used to channel funding towards health-maximizing products and services. New guidelines issued by the World Health Organization describe universal health coverage (UHC) as requiring the definition of "a comprehensive range of key services…well aligned with other social goals."[vi] Indeed, many countries planning UHC reforms use HBP as a means to understand and mobilize expenditure requirements associated with coverage expansions. In health systems that separate payment and provision functions, some variant of HBP is required to set expectations, organize payment systems and hold providers accountable for service delivery. Still others have argued that HBP are necessary as a means to spell out entitlements to the population as part of the right to health[vii], and to determine what is not covered so that individuals can self-insure for uncovered risks where possible (and insurance markets can develop)[viii]. The International Monetary Fund, the European Commission and the European Central Bank have recommended "streamlining" HBP to countries in economic crisis as a means to reduce public spending on health in the context of a fiscal crunch, or to identify essential health benefits.[ix] As a result of these multiple motivations, health systems in at least 65 low- and middle-income countries currently use some form of HBP as a policy instrument, with differing levels of explicitness and effectiveness.[x]

But while commonly invoked as a policy recommendation and used in practice, HBP and their associated processes share in common a surprising lack of scrutiny and evaluation. Beyond the 2004-2007 HealthBASKET project in Europe[xi], other limited literature[xii] and a forthcoming study on OECD countries[xiii], there has been little comparative analysis and forward-looking guidance specifically targeted to low- and middle-income country settings. *Health Benefits Plans in Latin America* by Giedion et al. (2014)[xiv] is a notable exception that explores motivations, scope, coverage and organization of plans in seven Latin American countries, and analyzes achievements and challenges. Further, work from Thailand on using health technology assessment (HTA) to inform coverage decisions[xv] and to design a benefits plan in reproductive health[xvi], from Chile on the plan of universal guarantees (AUGE)[xvii] and from Mexico on the use of benefits plans for resource mobilization and financial protection[xviii] have helped illustrate the potential of HBP to deliver health system objectives. Literature and experience on priority-setting and resource allocation in general, as well as HTA, cost-effectiveness analysis, evidence-based/informed policy and medicine, clinical guidelines, comparative effectiveness research, systematic reviews, and impact evaluation are also closely related and relevant areas, but have not been tightly linked to the process and practice of HBP design, adjustment and evaluation.

As a result, there is much more to be done to respond to LMIC and donor policymakers' most basic queries on a range of issues. A Ministry of Health official in Sierra Leone has written: "We are currently at one of the difficult stages of the design: Agreeing on the Benefit Package. Like most developing countries, several vertical programs are being implemented (e.g. free health care for pregnant women, lactating mothers and children under five, free malaria, TB, HIV, immunization, etc.). But should we integrate vertical programs into the benefit package? If yes, how? If no, how do we manage parallel programs?" A Global Fund for AIDS, TB and Malaria official has asked: "What you do with the cost-effectiveness threshold? What do you do for local cost estimates? What to do about effectiveness: local effectiveness data? Or from literature based on systematic review? Specifically for malaria: what about the elimination agenda? This may not be cost effective in short run, but effective in the long run." An official from Zambia writes: "What I found the problem in Zambian health sector is to expand the specialized services rapidly without looking at cost implications and huge financial gaps across the sub-sector including maternal and child health, HIV/AIDS, etc. So I think that we need to assess the priority of health intervention from the whole sector, not from the sub-sector such as HIV/AIDS and maternal health which is currently the practice in this country. How do

you do this kind of assessment?" In Turkey, officials ask: "how should we use HTA to improve the way pharmaceuticals are added to the formulary?" In Singapore, "how can we move to a more evidence-based and data-driven approach to reimbursement decision making?" In Chile, the public sector payer asks: "what processes and structures need to be established for determining non-prioritized interventions?" In Mexico, the Ministry of Health asks: "how can I better reflect existing health system characteristics and constraints in my current and future HBP?"

In general, policymakers would like to understand the options available to decide what's in and what's out, and what other countries have done. On balance, is a HBP a good idea in my health system, or not? What methods and criteria should underpin decisions, and how should or can these criteria be balanced? How will the plan be kept up to date? What processes and institutions are needed? What can be done about non-prioritized benefits? How will the standard package be defined legally, e.g. what legislative and other approaches should apply and how will these relate to definitions of services for payment purposes? How will disputes in relation to the scope and content of the standard package be resolved? How should we manage the complex political economy and ethical terrain in which HBP decisions are taken and implemented? And finally, how can we make HBP work in practice, aligning with other enabling health system functions like payment? How do we know if HBP are delivering on the motivations that led to their creation and implementation?

Aims of this book and web resource

This book [and web resource] will build on previous work and attempt to answer at least a few of these policymaker questions, or point readers in the right direction to more or better resources, with the triple goal of providing practical information, options and analysis of the "how-to" of HBP for policymakers, creating a living web resource around the book's themes and informing on-going support provided by IDSI and other country partners. The book will neither make a case for priority-setting in healthcare nor argue that health benefits plans are the only or best way to accomplish this goal, as this is covered adequately elsewhere.[xix] Instead, this book-resource starts with the HBP as a given, placing priority on consulting with policymakers currently engaged in HBP-related work and examining options and experiences in getting HBP to work in support of health system goals. While the resource will be aimed at LMIC policy audiences, it will draw on low- and high-income country experiences to enrich the discussion and examples provided.

The book-resource's main objectives are:

- To provide an overview of priority-setting in the context of publicly funded health care and UHC, and the role of HBP within these processes
- To assess and analyze options and practice in six thematic areas (see below) that are critical to HBP design, adjustment and evaluation
- To demonstrate key issues through practical country case studies or examples, with references to original source material
- To examine the implications for policymakers, politicians, regulators and others charged with the governance of health systems, and for external funders to LMIC health systems
- To set out a forward-looking agenda for policy, support and data related to HBP

Outline structure

This book necessarily covers a wide range of material. The criterion for inclusion is that the topic of HBP is an important matter for policymakers and regulators charged with oversight and stewardship of the health system. Throughout, the treatment will be aimed at the intelligent lay reader, and authors will be encouraged to avoid excessively technical material as well as jargon. The breadth of coverage demonstrates the magnitude of the challenge faced by policymakers. At present the outline suggests a total of 8-9 chapters, with a word count of about 7,000 each.

The book-resource will start with an overview of priority-setting and the role of plans/lists of various kinds, followed by a framework for the rest of the book, authored by the editors. This introduction will define HBP and provide readers with the essential policy background and context to guide them through the volume, while also highlighting the main concepts presented in the different sections and chapters. The link between UHC and priority setting will be explained. The section will identify what choices are made and by whom, at what levels (macro/meso/micro), and will examine the role and growing relevance of priority-setting using HBP in LMIC. Explicit versus implicit lists will be discussed with potential pros/cons and trade-offs, noting the context-specificity of all these choices and decisions. The section will lay out the "HBP cornerstone framework"[xx] as a simplified way to think about key issues and choices, and structure the remainder of the book. Different pathways and motivations to setting up HBP will be reviewed, reflecting a normative approach to HBP that would start from the premise that a health system should only finance and provide interventions and medications that work at no or low co-pay, fairly.[xxi] This section will also discuss key features required to move from a list on paper to interventions in practice (resources/budgeting, availability of inputs, institutional structures for decision-making and evaluation), and will provide an overview of constraints to the process citing Smith et al. IDSI paper.

These introductory sections will be followed by six thematic chapters covering the following topics as they pertain to the design, adjustment and evaluation of HBP:

1. Political economy issues
2. Governance, process and institutions issues
3. Technical and methods issues
4. Fiscal, budgetary and payment/commissioning issues
5. Ethical and equity issues
6. Data, monitoring and evaluation issues

We consider each topic briefly in turn. Each section will have a lead author/editor (indicated in underline) and will be accompanied by authors, co-authors and background papers, as appropriate. Policymaker roundtable reviewers and IDSI peer reviewers will also contribute to each section, while the editors will be responsible for producing the final version of the overall book-resource. With their permission, all contributors will be acknowledged explicitly in any published materials. A more detailed prospectus of the web resource will be prepared once the first draft of the book is completed.

1. *Political economy issues*
   Most analyses of and assistance to HBP in LMIC has focused on technical issues –cost-effectiveness models, training and methods- rather than the process, institutions and politics that *de facto* characterize decisions on coverage and reimbursement in the health. This section will map common features and constellations of political and economic interests related to HBP processes, describe political economy models that may be useful in understanding and managing interests, and identify practical strategies and leverage points used to address these issues and dynamics while assuring a fair process (conflict of interest, transparency, rules of the game/institutions, participation and deliberation, etc.). (TBD/Jesse Bump, Georgetown University)

2. *Governance, process and institutions issues*
   This chapter will discuss ideal governance, process and institutional attributes of HBP design, adjustment/disinvestment, enforcement and evaluation and discuss how these attributes have or have not been reflected in practice, with attention to the varying institutional and process arrangements that are possible and strategies undertaken to get around obstacles to better institutional design. Attention to conflict of interest, transparency and consultation. Tensions and links to related policies such as pricing, payment/reimbursement, prescribing and legal issues will also be discussed. More specific background papers from Chile, Ghana and Thailand will be referenced. Links will be made to the sections on political economy and ethics, among others. To the extent feasible, operational, legal and legislative issues and context related to governance, process and institutions will also be addressed, or key links provided.[4] (Ursula Giedion, CGD)

3. *Technical and methods issues (2-3 chapters)*
   This section will assess the technical and methods challenges to be addressed when defining a benefits plan – motivations, information asymmetry, universe and heterogeneity of possible benefits and their interaction with constraints of different kinds, and will evaluate the pros and cons of available evaluation methods with respect to these challenges: multi-criteria decision analysis, cost-effectiveness ratios, population-based cost-effectiveness analysis, and extended cost-effectiveness analysis, as well as program budgeting and marginal analysis. Issues will also be examined around framing benefits (level of detail, organizing principles, financial coverage), defining and applying priority-setting criteria, choosing what to evaluate in depth, costing services or defining reimbursement rates, calculating budgetary impact, methods issues related to making coverage decisions (thresholds and other options), and dealing with heterogeneity in costs and effects as well as information constraints, among others. Special attention will be given to practical approaches that low-income countries might use to set priorities at the margin. Disinvestment will also be considered. Case studies providing an overview of specific countries' technical and methods approaches will be included as part of this work, particularly a chapter focusing on Thailand with HITAP. (Peter Smith, Imperial College London)

4. *Fiscal, budgetary and payment/commissioning issues*
   This chapter will connect HBP to the fiscal, budgetary and payment/commissioning process, reviewing the extent to which countries use HBP to structure resource allocation, budgets and

[4] For example, operational information from existing processes such as contracts with universities; quality assurance mechanisms; personnel specifications and job descriptions, conflict of interest forms could be provided in the form of links.

transfers, and related. Conceptual and practical considerations for HBP will be addressed, from the way in which different health systems organize fiscal/budget/payment structures and how that might affect HBP, dealing with historical input-based budgets and HBP, informing resource allocation formula using HBP, and paying/commissioning/reimbursing using HBP. The section will also discuss how budget processes can fit with the priority-setting/HTA process and decision-making on coverage or reimbursement using HBP, as well as the role of budget authorities in the decision-making process. (Amanda Glassman, CGD)

5. *Ethical and equity issues*
   This section will examine current practice and provide practical guidance on navigating the equity and ethical challenges of HBP in specific contexts, safeguarding against egregious moral harms resulting from inappropriately devised resource allocation, and supporting the development of morally defensible benefits plans within the scope of what is feasible. The extent to which equity and ethics considerations can be embedded into cost-effectiveness analyses and health technology assessment processes in the context of HBP will also be discussed. Implications for governance, institutions and process in general will also be addressed, as will possible indicators and approaches to create accountability and track metrics related to stated commitments and impact on the most disadvantaged. (Carleigh Krubiner and Ruth Faden, Johns Hopkins University)

6. *Data, monitoring and evaluation (DME) issues*
   Motivated by the need to build consensus on the objectives, scope, input, processes, timeline and outcomes of HBP, DME will receive special attention as a means to promote learning, accountability and feedback loops that can regularly review new evidence or data and translate into improved HBP decisions and outcomes. The section will discuss key accountability and learning relationships around HBP (beneficiaries-system; providers-payers; payers-insurers; insurers/payers-stewards) and set out what to monitor and evaluate and what data is needed. Attention will also be given to routine performance reporting for governance, accountability, patient choice and related issues, crucial because quality assurance must be a key aspect of HBP and is often ignored. Issues of how, when and who will be charged with DME of HBP will also be discussed. (TBD)

Policy roundtable members

- Abdul Bakar-Kamarra, Ministry of Health, Sierra Leone
- Bilgehan Karadayi, Ministry of Health, Turkey
- Biljana Kozlovic, Health Insurance Fund, Serbia
- Eduardo Gonzalez-Pier and Giota Panopoulou, Ministry of Health, Mexico
- Fajri Adinur, National Health Insurance, Indonesia
- Jeanette Vega Morales, National Health Fund, Chile
- Kalipso Chalkidou, NICE, UK
- Martha Gyansa-Lutterodt, Ministry of Health, Ghana
- Phuong Nguyen Khanh, Health Strategy and Policy Institute, Vietnam
- Rajeev Sadanandan, RSBY, India
- Nathalie Phaholyothin and Robert Marten, Rockefeller Foundation
- Sudigdo Sastroasmoro, Ministry of Health, Indonesia
- Yot Teerawattananon and Nattha Tritasavit, HITAP, Thailand

- Henry Irunde, Ministry of Health, Tanzania
- Denizhan Duran, CHAI on behalf of Ministry of Health, Malawi
- Beth Woods, University of York
- Alec Morton, University of Strathclyde
- Andreas Seiter, World Bank

Timetable

August 25-26, 2014	Policymaker roundtable with discussion of prospectus
September 9-12, 2014	IDSI partners meeting with discussion of prospectus
December 30, 2014	First drafts of three chapters or background papers completed
March 31, 2015	First drafts of rest of chapters or relevant background papers
May 1, 2015	Deadline for roundtable and IDSI reviewer comments
August 30, 2015	First draft of complete manuscript and prospectus for web/wiki resource
October 2015	Consultation draft of manuscript and preliminary skeleton of web resource
October 2015	Stakeholder/roundtable meetings around consultation draft manuscript
January 2016	Launch and publication of book and resource
Through March 2016	Consultation and feedback with regular updates to web resources

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