

Health benefits packages for UHC: wrench in the works or keys to control?

**Presentation for the
Workshop on Design and Adjustment of HBP**

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Center for Global Development

March 6, 2017

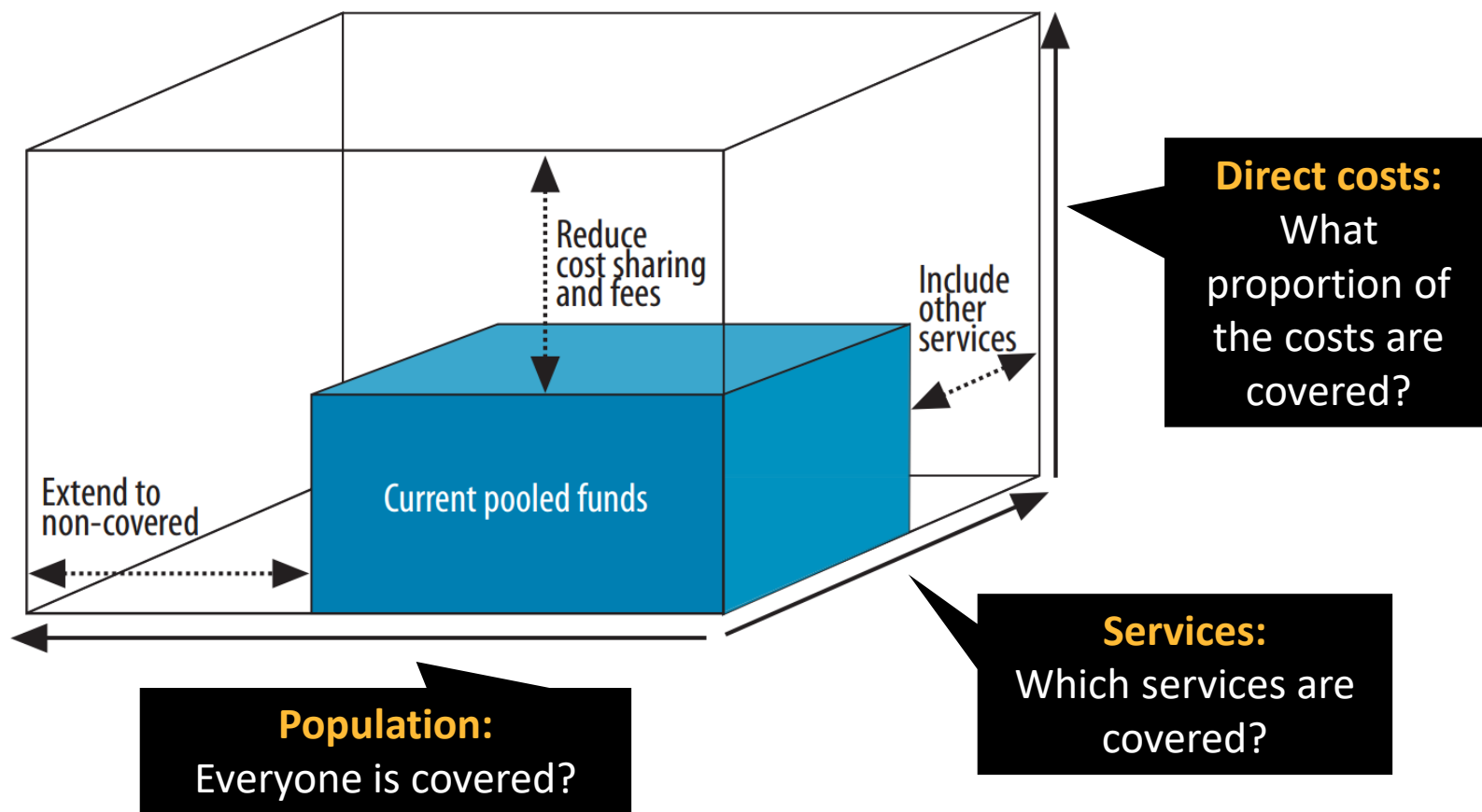
Structure of presentation

1. Why health benefits plans (HBP) for UHC
2. Defining HBP
3. How could HBP help with UHC goals and functions
4. HPB policy cycle
 - Tour through a few steps
5. Some common pitfalls
6. Main messages

1

WHY HBP FOR UHC?

Balancing coverage with available financing is the UHC imperative



Competing priorities and interests at many levels in ad hoc or inertial process of resource allocation = implicit rationing

Many 'priorities'...



Asthma management in general practice

A chronic disease health priority

PRESS RELEASE

Sept. 19, 2011, 5:33 p.m. EDT

American Heart Association Urging Action at UN Summit on Non-Communicable Diseases

Organization Calls for More Focus on Cardiovascular Diseases - the World's No. 1 Killer

Palliative Care: A Public Health Priority in Developing Countries

Reproductive cancers: high burden of disease, low level of priority

...many interests

MSF asks India to make affordable hepatitis C medicines as Natco resists expensive US drug patent

•12-04-2014

•By Sehat

•[Bookmark](#)



The new drug war

Hard pills to swallow

Drug firms have new medicines and patients are desperate for them. But the arguments over cost are growing

Jan 4th 2014 | NAIROBI AND NEW YORK |

It gets personal quickly



- Colombia: Camila Abuabara
- Sues for public coverage of a liver transplant in US hospital
- Twitter:
 - *Ministro de salud @agaviriau me condena a la pena de muerte en Colombia y según él yo debo de aceptar gustosa junto a su compinche de EPS*

And *ad hoc* practices lead to inequities...

- Hospital committees that decide who gets a spot under limited dialysis budget:
 - In South Africa, between 1988 and 2003, white patients were nearly four times more likely to be accepted for dialysis treatment than nonwhites (NPR 2010, Sheri Fink)
- Patients sue for public coverage, opportunity costs not considered by legal system
 - Rafael Favero, a patient with a rare anemia, sue for a \$440,000 drug and wins in Brazil
(<http://revistaepoca.globo.com/tempo/noticia/2012/03/o-paciente-de-r-800-mil.html>)



And *ad hoc* practices lead to inequities...



[News](#) | [Science](#) | [Health](#) | [Nation](#)

GOP Seeks Reduction In Affordable Care Act's 10 Essential Benefits

by **Michelle Andrews**

NPR | Feb. 22, 2017 7:04 a.m.

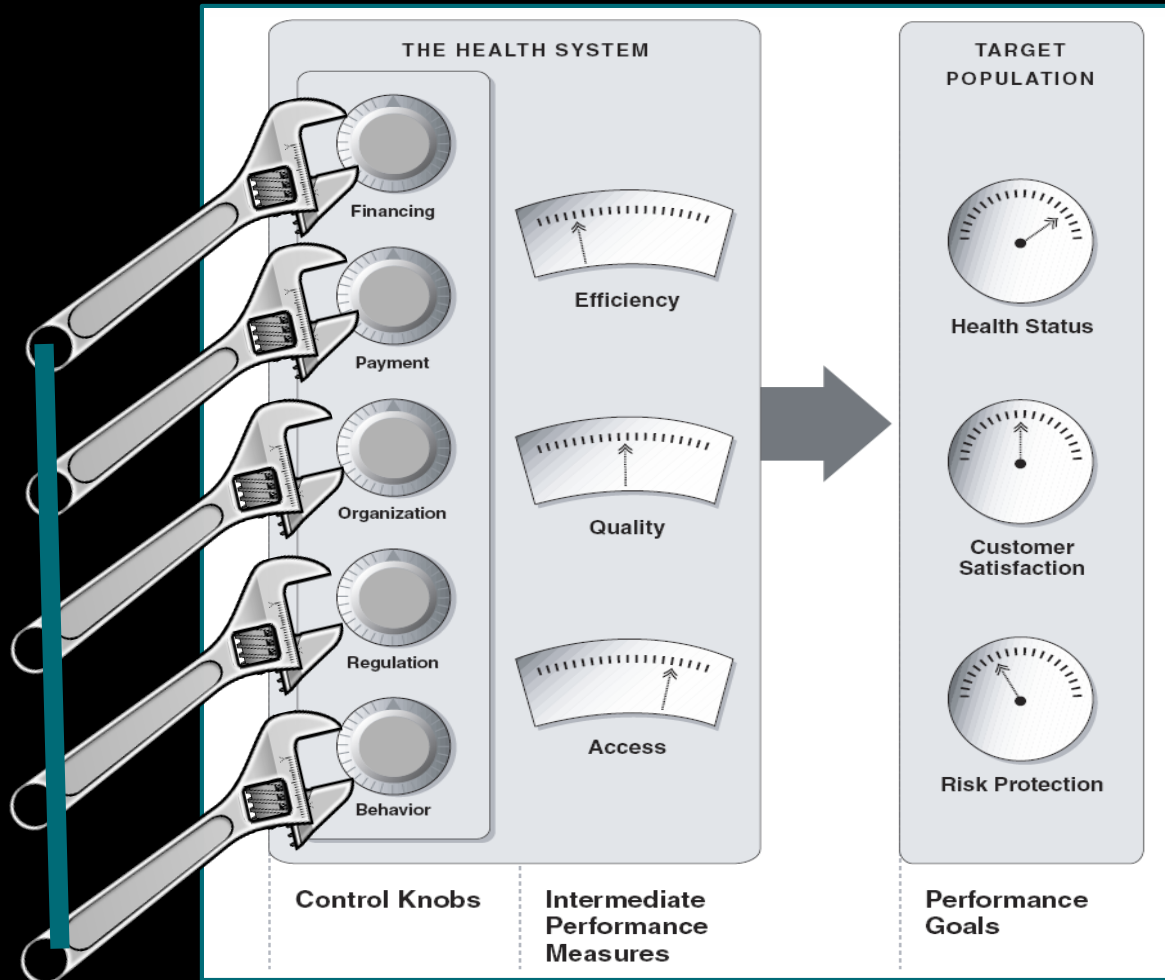
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DEFINING HBP

Defining health benefits plan

- Minimum attributes:
 - Total size is constrained by available funds
 - Completely or partially constrains products and services available through health system
 - Comprises a portfolio of products and interventions
 - Not a single technology, not a vs. b
- Not:
 - Ad hoc rationing or implicit resource allocation (using budget until \$ runs out then user fees or no provision, or constraining supply capacity)
- A technical but also political, procedural, institutional, fiscal, ethical and legal undertaking
 - Informing all relevant health system functions in order to be effective

Content, scope and depth of benefits: key to connect between control knobs and outcomes (or the wrench in the works)



Source: Roberts et al. Getting health reform right. New York: Oxford University Press, 2004.

Many LMIC establish HBP in both health insurance schemes and tax-funded systems

Low- and Middle-Income Countries with Health Benefit Plans

World Bank developing country group	Countries
Central and Eastern Europe	Health insurance schemes: Azerbaijan, Bulgaria, Croatia, Estonia, Georgia, Hungary, Kyrgyz Republic, Lithuania, Macedonia, Moldova, Poland, Romania, Russian Federation, and Slovenia Tax-funded systems: Armenia, Kazakhstan, Slovak Republic, and Tajikistan
Latin America and Caribbean	Health insurance schemes: Argentina, Chile, Colombia, Dominican Republic, Nicaragua and Uruguay Tax-funded systems: Argentina, Bolivia, Brazil, Honduras, Nicaragua, Peru
Asia	Health insurance schemes: Lao PDR, Philippines, and Vietnam Tax-funded systems: Cambodia, China, India, Malaysia, and Thailand
Middle East and North Africa	Health insurance schemes: Egypt, Israel, Lebanon, Malta, Syria, Tunisia, United Arab Emirates, West Bank and Gaza, and Yemen Tax-funded systems: Bahrain, Djibouti, Jordan, Morocco, Oman, Qatar, and Saudi Arabia
Sub-Saharan Africa	Health insurance schemes: Ghana, Kenya, Namibia, Nigeria, Senegal, South Africa, Tanzania, and Uganda Tax-funded systems: Uganda and Zambia

Source: Glassman & Chalkidou, "Priority-Setting in Health: Building institutions for smarter public spending," a report of the Center for Global Development's Priority-Setting Institutions for Global Health Working Group, 2012

*check UNICO update to list

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HOW HBP ARE USED TO IMPROVE UHC OUTCOMES

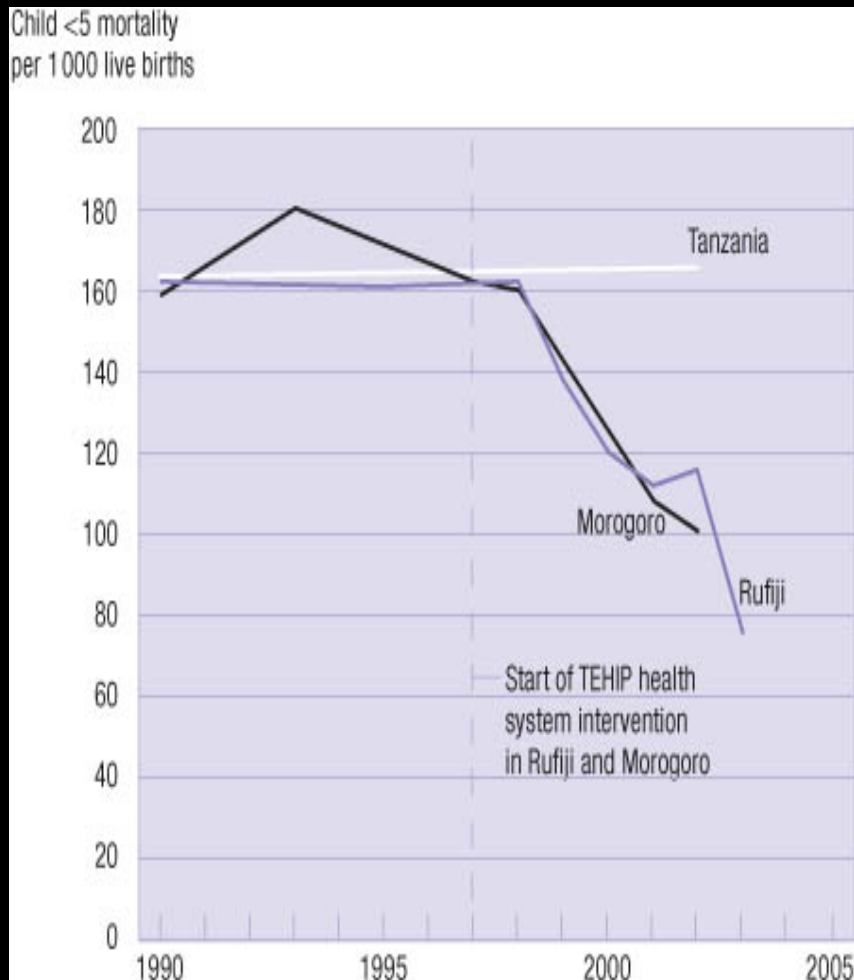


How can health benefits plans help achieve UHC outcomes and functions?

- Maximizes health, enhances value for money
 - Introduces greater evidence into public spending decisions
 - Incentivizes the development of cost-effective new technologies
 - Informs pricing negotiations
- Informs provider commissioning or payment
- Informs budget expansions or as input to sizing of fiscal transfers
- Cuts costs, reduces waste and harm
- Provides the means to regulate private health insurance
- Enhances equity and reduces care variations
- Improves accountability between payers, providers and patients

Maximizes health:

remember the Tanzania Essential Health Interventions Project (1997-2002)?



- Prospective follow-up study in two districts with 741,000 population (DSS + verbal autopsy)
- Essential health benefits package defined based on district-level cost-effectiveness data
- District Health Management Teams (DHMT) allocated budget based on per capita cost of package and population size
- DHMT can deploy resources flexibly
- Accompanied by training, tools, support

Maximizes health:

Chile's AUGE increases production and utilization of high-value services

- Identification of 56 (now 80) prioritized health problems (based on multiple criteria)
- 75% burden of disease
- Associated clinical guidelines based partially on cost-effectiveness (446)
- Associated interventions (8005)
- Guarantees of access, financial protection, timeliness of care
- Rest is still provided but without guarantees

Maximizes health:

Chile's AUGE increases production and utilization of high-value services

Health problem	Hospitalization rate 2000-2006	Case-fatality rate 2000-2006
Hypertension	10% drop	11% drop
Type 1 diabetes	7% drop, especially among patients older than 30 years; steepest drop seen among ISAPRE beneficiaries	48% drop
Type 2 diabetes	13% increase, especially among older adults (older than age 65); steeper increase (72%) among ISAPRE beneficiaries, possibly because of better access to care or—to some extent—to population aging	Hospital death rate dropped 5%—a noteworthy finding given that this is an older, higher-risk population
Epilepsy	8.9% combined increase for all age groups; 11.4% observed increase among patients younger than age 15 (target population of AUGE); eightfold increase among ISAPRE beneficiaries	98% drop in fatality in all cases; no data are available to distinguish that rate between the population of AUGE beneficiaries for this disease (younger than age 15)
Depression	26% increase for the entire population, 45% increase among adolescents; fivefold increase among ISAPRE beneficiaries	98.6% drop
HIV/AIDS	24% global drop, a large part of which comes from children and adolescents who are beneficiaries of FONASA	56% drop

Enhances value for money: Thailand's HTA-informed universal coverage package

Drugs under consideration	ICER (Baht/QALY)	Coverage decisions	Year
pegylate interferon alpha 2b plus ribavirin for treatment of chronic hepatitis C sybtype 1 4 5 & 6	cost-saving	Yes	2011
pegylate interferon alpha 2a plus ribavirin for treatment of chronic hepatitis C sybtype 1 4 5 & 6	cost-saving	Yes	2011
lamivudine or tenofovir for treatment of chronic hepatitis B	cost-saving	Yes	2011
simvastatin for primary prevention of cardiovascular disease	82,000	Yes	2009
Galantamine for treatment of mild-to-moderate Alzheimer's disease	157,000	No	2010
donepezil, rivastigmine for treatment of mild-to-moderate Alzheimer's disease	180,000-240,000	No	2010
osteoporosis drugs (alendronate, residronate, raloxifene) for primary and secondary prevention of osteoporotic fractures	300,000-800,000	No	2009
atorvastatin, fluvastatin. pravastatin for primary prevention of cardiovascular disease	negative dominant	No	2009
recombinant human erythropoietin (rHuEPO) treatment in chemotherapy-induced anemia	negative dominant	No	2008
adefovir, entecavir, telbivudine, pegylate interferon alpha 2a for treatment of chronic hepatitis B	negative dominant	No	2011

Enhances value for money: Thailand's UC decisions have more than paid off economic evaluation costs

Annual cost of HITAP: 37 mn Thai baht (0.007% of THE in 2010)

	Description	Impact	
Prevention of cervical cancer (2007)	<ul style="list-style-type: none"> Assessed possibility of universal coverage of the HPV vaccine using cost-effectiveness analysis Compared multiple scenarios to conclude that the most cost-effective strategy would be improving screening accessibility rather than universal vaccination 	<ul style="list-style-type: none"> Health gains: 1500 averted new cases and 750 female deaths per year Cost savings: 6 million international dollars, approximating 0.02% of the total health expenditure budget in 2007 	<p>Cost savings from the cervical cancer screening assessment alone more than covered HITAP's operating costs (0.01% of THE budget in 2007)</p>
New drug regimen in PMTCT of HIV (2010)	<ul style="list-style-type: none"> Assessed value-for-money of three-ARV regimen vs. current AZT monotherapy and single dose of nevirapine Solved social debate regarding feasibility and value for money of a new drug regimen in PMCT of HIV 	<ul style="list-style-type: none"> Health gains: 101 paediatric HIV infections averted annually Cost savings: 2.6 million USD over a lifetime 	

Informs provider commissioning or payment: China's provider payment method reform



- Over use:
 - Source from 6000 prescription survey
 - Antibiotics 42%
 - Hormones 15%
 - Vitamins 69%
 - NDRC deputy director address in 18th NPCSC
 - IV injection 10.4 billion bottles in total 2010, 8 bottles/person, far above the 2.5 to 3.3 bottles international level

Informs provider commissioning or payment: China's provider payment method reform (FFS → DRG)

序号	项目内容	类型	控制方式	判断方式	婴儿特殊类型	操作人员	操作时间
8	术后医嘱 (必选)	医嘱	强制	手工录入	<input type="checkbox"/> 常规	系统管理	2011.06.08 16:48:35
9	术后常规医嘱		提示	根据程序项目判断	<input type="checkbox"/> 常规		2011.06.08 16:49:16
10	孕妇低流量吸氧 (术后必要时) (可选)		不控制	根据程序项目判断	<input type="checkbox"/> 常规		2011.06.08 17:12:14
11	新生儿护理常规 (必选)		强制	根据程序项目判断	<input checked="" type="checkbox"/> 常规		2011.06.08 17:14:08
12	母婴同室 (必选) (有禁忌者除外)		提示	根据程序项目判断	<input checked="" type="checkbox"/> 常规		2011.06.08 17:14:57
13	母乳喂养 (必选) (有禁忌者除外)				<input checked="" type="checkbox"/> 常规		2011.06.08 17:15:19
14	脐部护理 (必选)				<input checked="" type="checkbox"/> 常规		2011.06.08 17:18:06
15	生物活性脐带卷 (可选)		不控制	根据程序项目判断	<input checked="" type="checkbox"/> 常规		2011.06.08 17:19:04
16	新生儿吸氧 (可选)				<input checked="" type="checkbox"/> 常规		2011.06.08 17:19:49
17	静脉输液 (必选)		提示	根据程序项目判断	<input type="checkbox"/> 常规		2011.06.08 17:21:29
18	抗生素 (必选)				<input type="checkbox"/> 常规		2011.06.08 17:32:33
19	缩宫药物 (必选)				<input type="checkbox"/> 常规		2011.06.08 17:34:49
20	维生素K1 5mg in (新生儿) (必选)				<input checked="" type="checkbox"/> 常规		2011.06.08 17:36:45

Priority: 100% covered by NCMS.
Min cost



Selected: 30-40% covered by NCMS.
Potential cost



Ceiling reimbursement price established
If savings: shared by hospital and doctors

LOS

Necessary

Optional

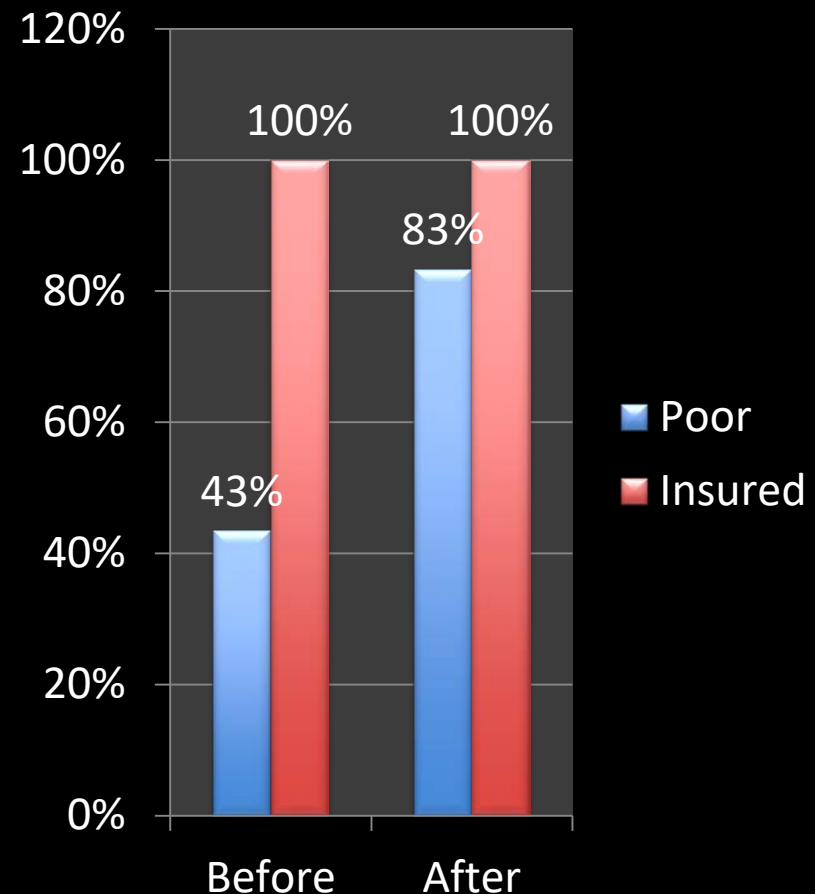
OOP costs capped @ lower levels

Informs budget expansions and sizing of fiscal transfers: Mexico's Seguro Popular package

Example Mexico/Seguro Popular:

«..[.]The benefits package was meant to help correct this inequity by guaranteeing the allocation of a specific amount of money per person. By establishing the content and cost of the Seguro Popular Benefits Package, **it was possible to make the resource requirements evident**. This in turn helped to mobilize additional resources. As a result, the differences in per capita spending were reduced to 1.2 x.» (Knaul et al, 2012).

Per capita packages in Mexico
SSA vs IMSS



Source: Giedion, U. 2013

Reduces waste or outright harm:

Romania's Basic Package of Health Services and Technologies

Quick assessment to revise medicines list using the following criteria:

- Medicines listed for indications outside the terms of their marketing approval (ie off-label).
- Medicines listed for indications or in settings in which they may not be cost effective.
- Medicines considered cost effective in other jurisdictions but unlikely to be cost effective at current Romanian prices.
- Medicines for which subsidy is not justified by a high risk/benefit, irrespective of registration status.
- Medicines that may not reflect a high value for money in a resource-limited environment.

For example:

According to Romanian treatment protocols, **bevacizumab** may be prescribed for first-line treatment of metastatic breast cancer

Recommendation: As the use of **bevacizumab** in breast cancer is no longer an approved indication, the subsidy should be discontinued.

Provides the means to regulate private insurers: South Africa's private medical schemes

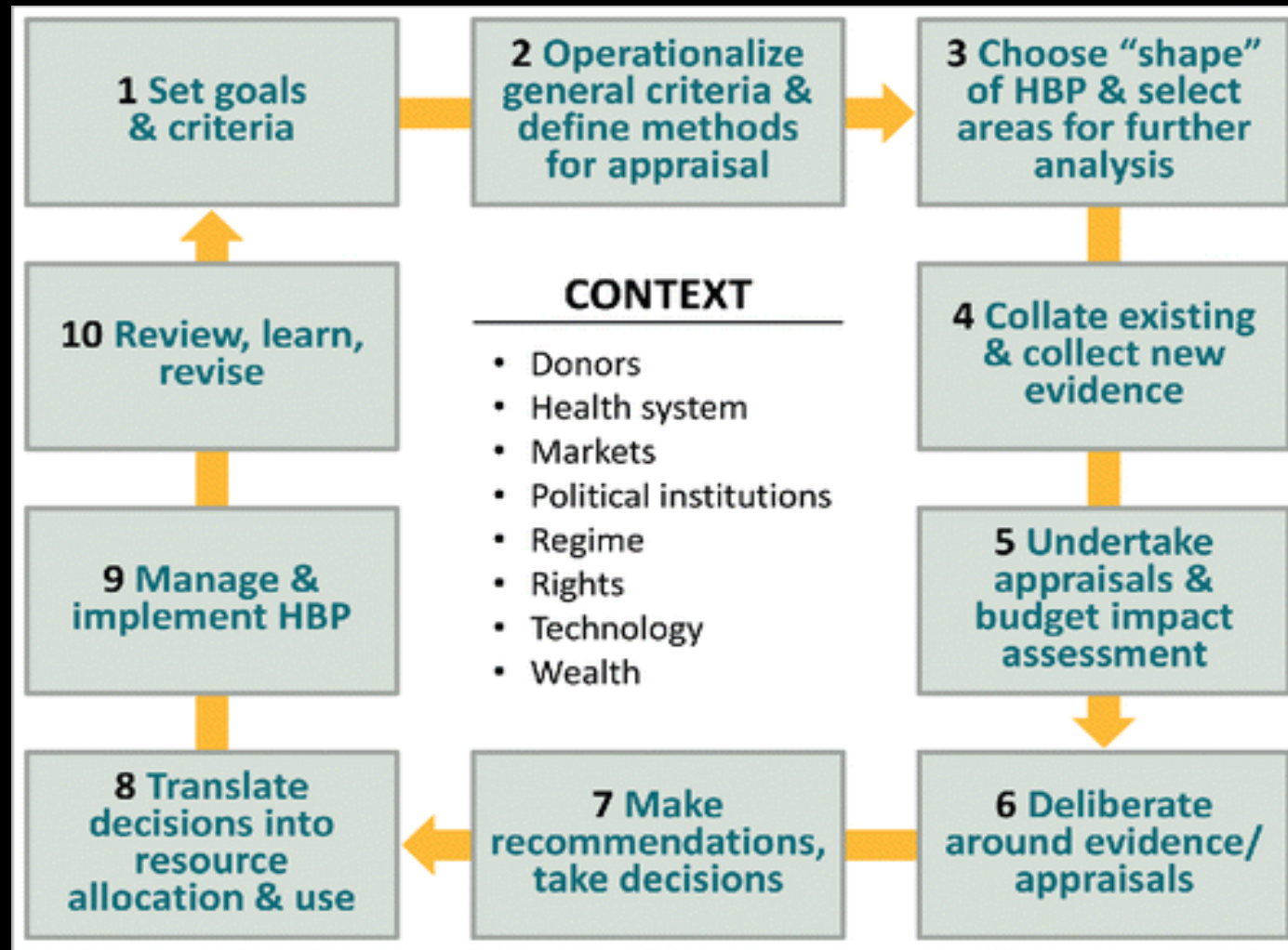
- Regulator: Council for Medical Schemes
 - Protect members of medical schemes (42% of THE)
- Open enrollment, community rating, mandatory minimum benefits
 - Regulation 15D(b)
 - “... managed health care programmes use documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost-effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions”*
- Regulation applied by the Council for medical schemes and independent appeal board

(Medical schemes are not for profit)

4

HBP POLICY CYCLE

Ten core elements of setting a health benefits plan



Step 1: defining high-level goals and criteria, a job for politicians and stakeholders

POLITICS

Must be feasible and sustainable politically over time

Economics

- Must protect people against impoverishment
- Must be affordable now and in future
- Must maximize the number of people with coverage
- Must address market failures that result in incomplete insurance

Ethics

- Distribution of public spending fair and transparent
- Duty to protect most vulnerable
- Stewardship of limited resources requires attention to maximizing health benefits
- Methods transparent, participatory, equitable, consistent, sensitive to value, responsive to new information, encouraging to innovation

HBP

Evidence

- Should only support safe, medically effective
- Should provide best scientific evidence to clinical decision-making
- Should address medical concerns of greatest importance to the “population”
- Should facilitate “right care to right patient in the right setting at the right time”

Population Health

- Should facilitate efforts to improve population health
- Primary, secondary and tertiary prevention needs attention
- Access for the vulnerable must be assured
- Disparities should be eliminated

Step 2: operationalize criteria and define analytical methods, a job for technocrats and academics with input from stakeholders

- Criteria start generic –“health”, “financial protection”, “equity”- but then have to be operationalized
 - Health measured in deaths, morbidity, severity, QALY, DALY?
 - Financial protection using insurance theory: choose high-cost, unpredictable condition-treatment pairs? Financial protection using OOP: perverse incentives?
 - Can sometimes be reflected in methods (ECEA, age weighting, poverty weighting)

Step 2: define methods

- Methods relate to several pieces of HBP decision-making, but can be set generically for each, always with relation to goals:
 - Methods to decide where to start or what next (next step: triage)?
 - Elicit stakeholder priorities (health problems, for example) or values/preferences
 - Methods to conduct HTA/appraisal, budget impact analysis?
 - Reference cases or methods manuals and guidelines
 - CEA but beyond CEA too, incorporating constraints of all kinds in models (ie variability in supply capacity)
 - Methods to make recommendations?
 - Decision rules, thresholds, evidence quality
 - Deliberative process, rules of the game

Step 3: choose the “shape of HBP”

- Macro choices that frame scope of HBP, linked to goals and use:
 - By type of service or product
 - By population group
 - » How coverage choices interact with HBP (fragmented systems vs universal)
 - » Capacity to benefit
 - » Appropriateness criteria
 - Example: Avastin® in Ontario
 - By level of complexity or frequency
 - By disease
 - By level of subsidy (co-pay)
- Also: structuring coding of HBP
 - link to budget/payment reform
 - ICD, DRG, etc.
 - International coding system for public health and prevention?

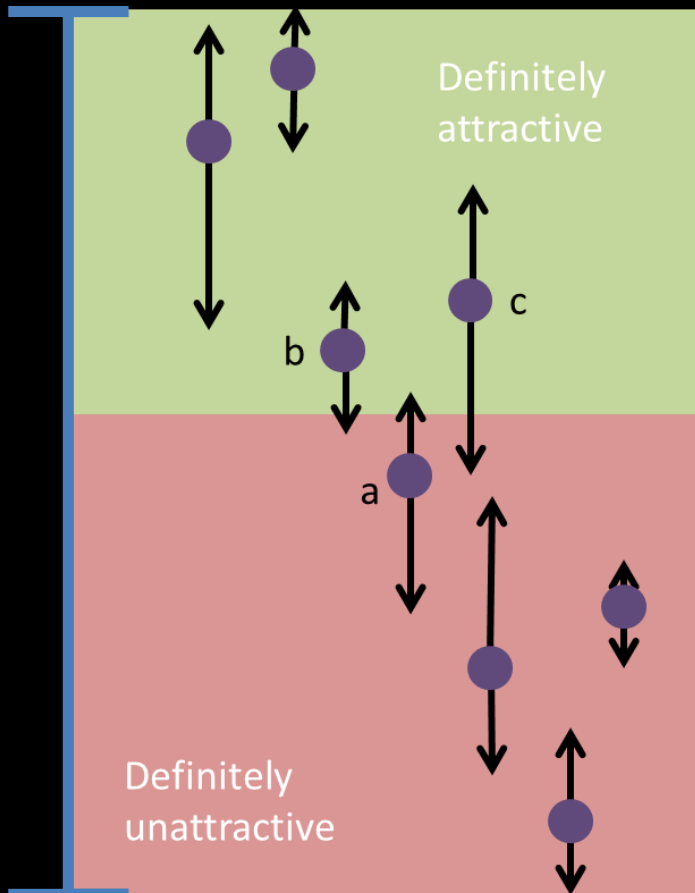
For example:

Uruguay: list organized by type of care, 1 unique list for low and medium level care, one list for high complexity-cost.

Colombia: organized by type of services and associated products in chapters: ambulatory care, hospitalization, oral health, etc.

Chile: by health conditions and care guidelines

Step 3: select areas for further analysis



- India: all services and products currently reimbursed by insurer (RSBY) are included in HBP; all new inclusions will follow new process?
- Romania: eliminate all never-evaluated and/or experimental products as first step
- DR: eliminate all neighbors' and NICE "no" products
- Thailand: eliminate product (glucosamine) from list for safety reasons

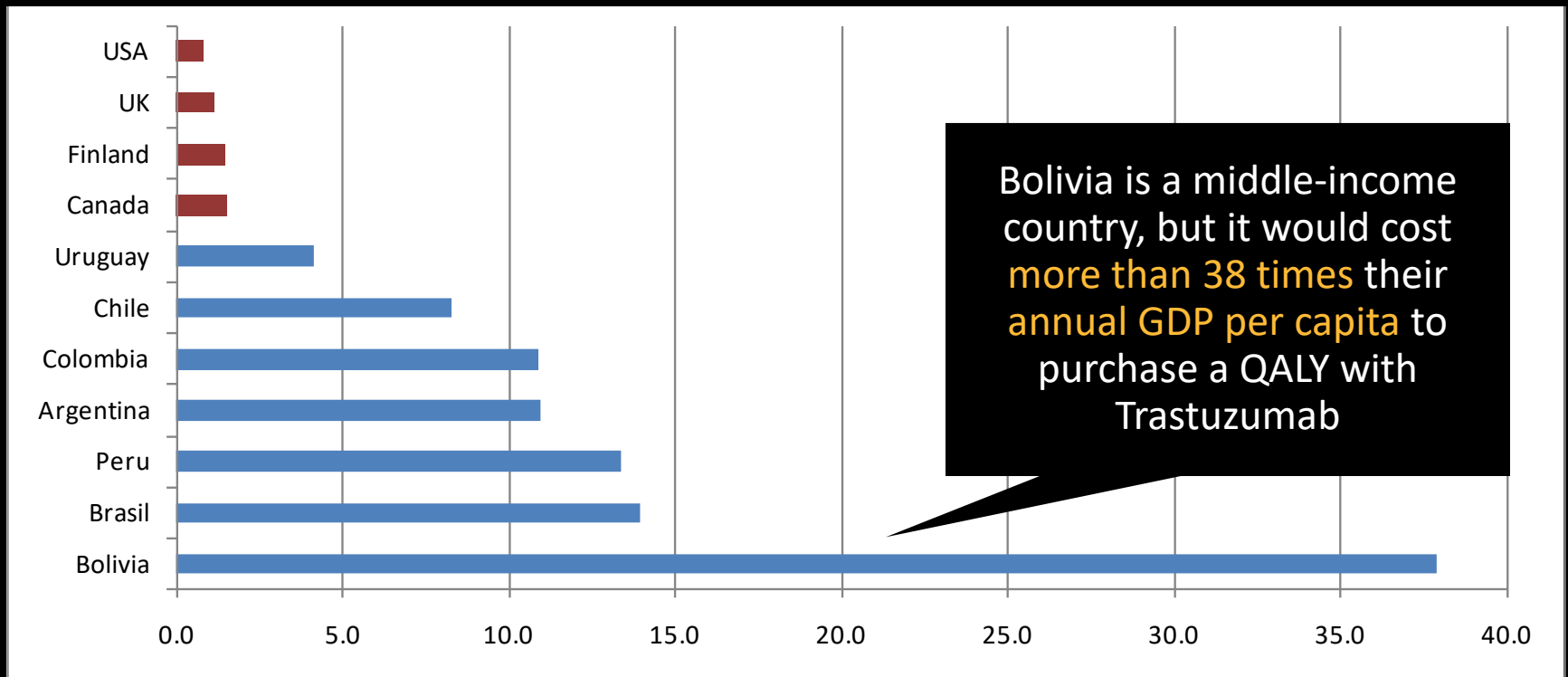
Step 3: what merits further analysis - a lack of process is a common feature in 4 countries

HTA for HBP in selected middle-income countries: How and why topics are selected

Country/Entity	Process for topic selection
Brazil/ANVISA/CITEC	<ul style="list-style-type: none"> • No formal process • The definition of priorities has been made through an Annual Workshop on Priorities
Chile/CCA	<ul style="list-style-type: none"> • No formal process. Topic selection is carried out by the CCA
Colombia/CRES	<ul style="list-style-type: none"> • No preestablished process for topic selection • In 2011 for the first time a more systematic process was used, but this has not been institutionalized in Colombian Law
Uruguay/FNR/MoH	<ul style="list-style-type: none"> • There is no formal process for topic selection • Both the MoH and the FNR define the topics, recent market access drives choice
Thailand/HITAP	<ul style="list-style-type: none"> • Representatives of four groups of stakeholders (health professionals, academics, patient groups, and civil society organizations) are appointed to sit on a panel overseeing intervention prioritization • Panel introduces six agreed criteria • A scoring approach with well-defined parameters and thresholds employed to address each criterion

Step 4: Data and evidence -- whereas efficacy is global, cost-effectiveness and affordability (and preferences/values) are local

Cost-utility of Trastuzumab expressed as number of GDP per QALY



Source: Andrés Pichon-Riviere , 2013. La aplicación de la evaluación de Tecnologías de Salud y las evaluaciones económicas en la definición de los Planes de Beneficios en Latinoamérica

Step 8: Allocate resources consistent with HBP content in every fiscal period

- Initial costing and capitation calculations, fit with budget availability overall
- Planning to adjust for inflation
- Incorporating scale up over time in capitations/payments to lower-capacity providers or local governments

Governance arrangements that frame the cycle are as important as the cycle

Attribute	Examples of good governance	Examples of bad governance
Accountability	NICE is hold accountable by parliament and media on the recommendations it makes	In Mexico, there are no systematic adjustment processes for CAUSES or FPGC In Colombia the executive branch doesn't explain why certain inclusion decisions were made and whether the BP actually focuses on sanitary goals
Transparency	In Chile, the costing update studies are published and publicly available	Colombia, the original technical priority-setting studies used to design the HBP were lost and nobody really knows how decisions are made and on what criteria. In Uruguay, none of the documents explaining how the universal package was designed is publicly available
Responsiveness	Colombia periodically updates its benefits package	Dominican Republic has never updated its BP since its inception in 2001

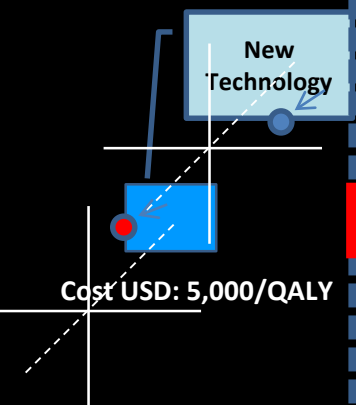
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COMMON PITFALLS

Where things can go wrong – common pitfalls

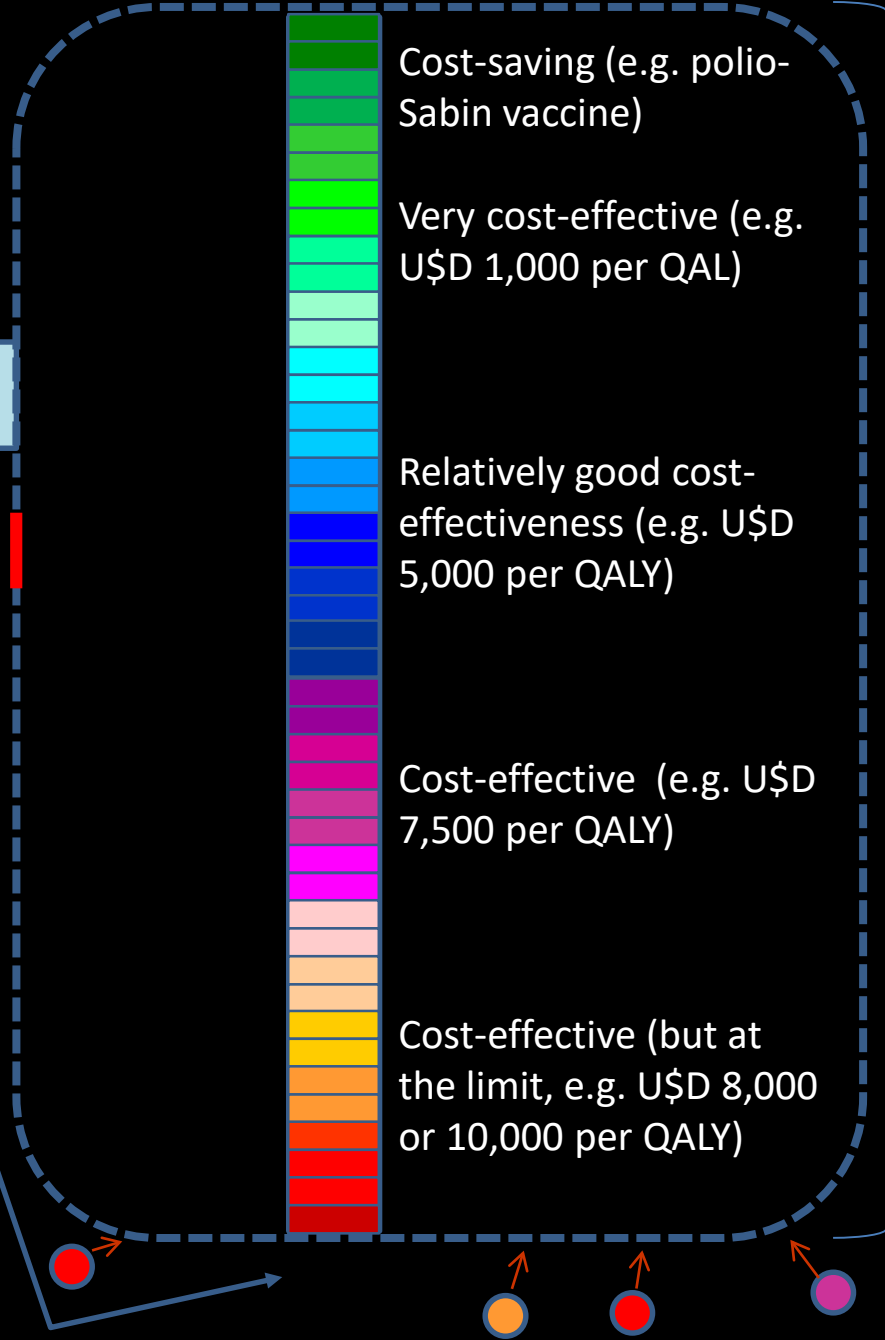
- Failing to account for supply (and other) constraints
- Not considering opportunity costs of new inclusions
- Legislating specific benefits
- Setting up separate high cost drugs packages or funds
- Omitting primary care and prevention, fragmenting care
- Forgetting about ethics, transparency and process
- Allowing indefensible inclusions
- Permitting erosion of value over time, divorce from budget process
- Missing local data on costs

This limit is imposed by the constrained health care budget



New health technology with a cost-effectiveness ratio of U\$D 25,000/QALY

Technologies that will be displaced offered less "value for money". The benefit gain from the new treatment is greater than the benefit foregone



Is the benefit gain from the new treatment greater than the benefit foregone through displacement?
No. Displaced technologies offered better "value for money" (the healthcare system loses "health" and efficiency)

HBP of an imaginary country where the Ministry of Health (many years ago) defined a cost-effectiveness threshold of U\$D 10,000 per QALY in order to consider a technology as cost-effective and allow its incorporation into the benefit plan.

Ghana's NHIS: legislated benefits, didn't consider supply capacity, excludes prevention, inconsistent with available resources

STRENGTHS

- Comprehensive service coverage
- Covers both formal and informal sector
- Poor and vulnerable catered for in broad exemption policy
- Does not require co-payment and co-insurance

WEAKNESSES

- Inclusion list is not clearly defined
- Costly
- Has been in use for 10 years without reform
- Encourages provider and subscriber moral hazards
- Disease management protocols are not defined
- Excludes preventive care

OPPORTUNITIES

- Possibility of developing an all- inclusive maternal health package of services
- Common non communicable diseases can be managed with all inclusive package of service
- Review of portability feature

THREATS

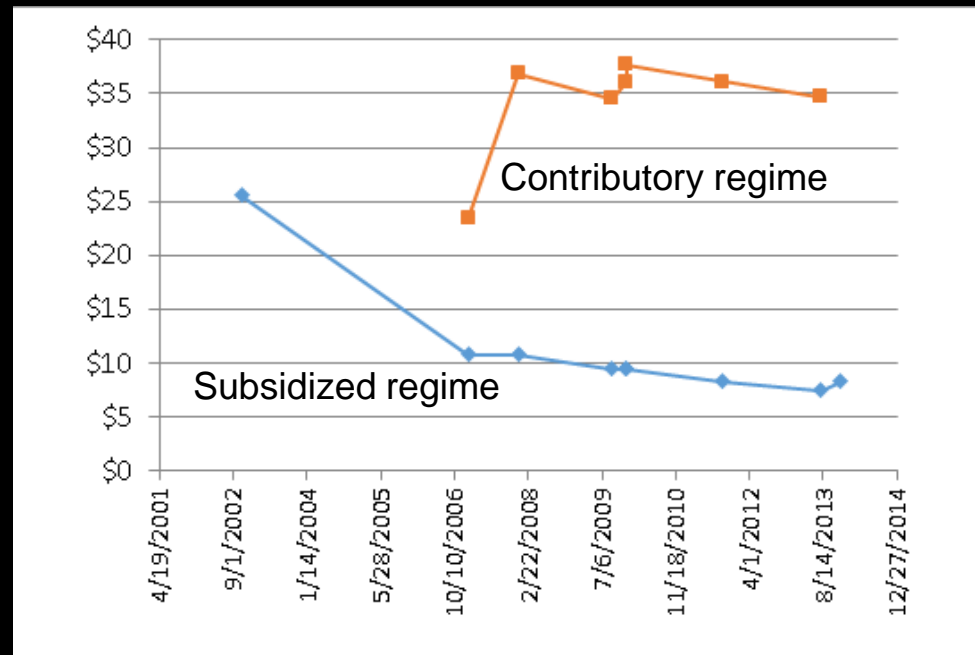
- Depletion of fund reserves
- Political pressure and interference
- Advocacy for increased coverage from patient groups and civil society
- Pressure from provider groups



Erosion of value: insufficient funding and eroding value in DR and Uganda

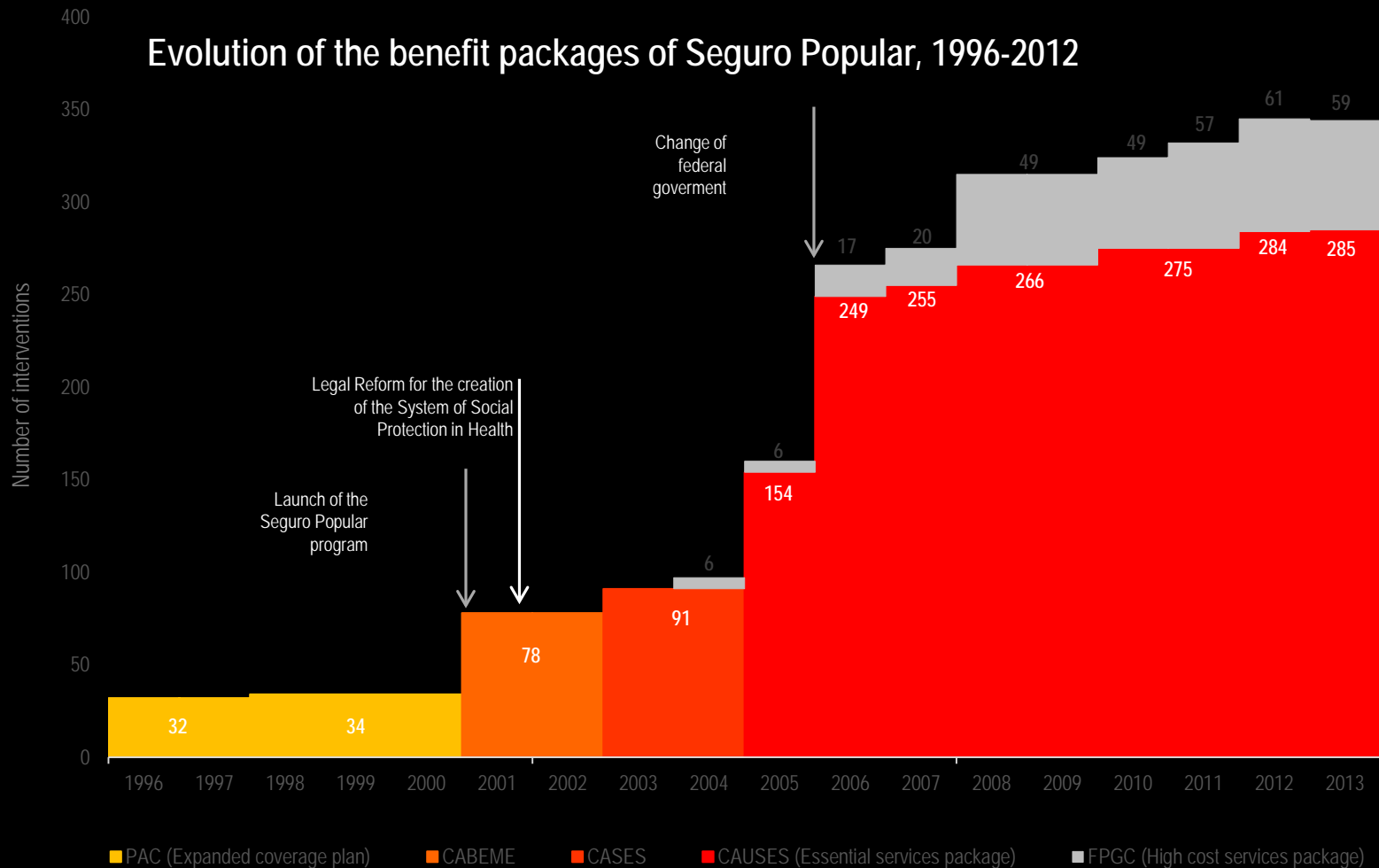
In Uganda, a package of services costing **\$41** dollars was expected to be delivered at a per capita actual expenditure of **\$12.50**.
Source: Tashobya et al 2003

Capitation payments to provide BP in
Dominican Republic
US\$, constant, 2001-2014



Source: Giedion et al 2014

Erosion of value: number of inclusions increase but funding only adjusted for inflation



Source: Panopoulou for 2013, Sistema de Protección Social en Salud. Informe de Resultados, 2013.

Lack of transparency and formal process

Attribute	Examples of good process	Examples of poor process
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6

MAIN MESSAGES

Main messages

- HBP that will have UHC impact are much more than lists or technical analyses
 - Good list is necessary but not sufficient
- Effective HBP are a “wrench” that adjust all other control knobs
 - Financing, payment, organization, regulation, behavior
- They are widely used, but require continual adjustments and reform to enhance effectiveness and assure sustainability
 - Not a one-off consultancy, requires permanent home and capacity
- Guidance and support from international community mainly focused on cost-effectiveness methods, tools and capacity-building
 - Important but need to consider full set of issues
 - Multidisciplinary! Health, economics, ethics, fiscal, governance
- Process is as important as outcome for effectiveness and sustainability
 - Needs to be (widely perceived as) fair, ethical, transparent, defensible in court!
 - With a view to manage not ignore legitimate competing interests