WEBINAR TRANCRIPTION:

THE USE OF HEALTH BENEFIT PACKAGES (HBP) IN THE EASTERN MEDITERRANEAN REGION

Presented by Dr. Awad Mataria and Hassan Salah. June 21, 2018.

IDB

CRITERIA

Social Protection and Health Division
Inter-American Development Bank
http://www.iadb.org/Health - scl-sph@iadb.org

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THE USE OF HEALTH BENEFIT PACKAGES (HBP) IN THE EASTERN MEDITERRANEAN REGION

June 21, 2018

This transcription is based on the webinar presented by Dr. **Awad Mataria** and **Hassan Salah** to CRITERIA.

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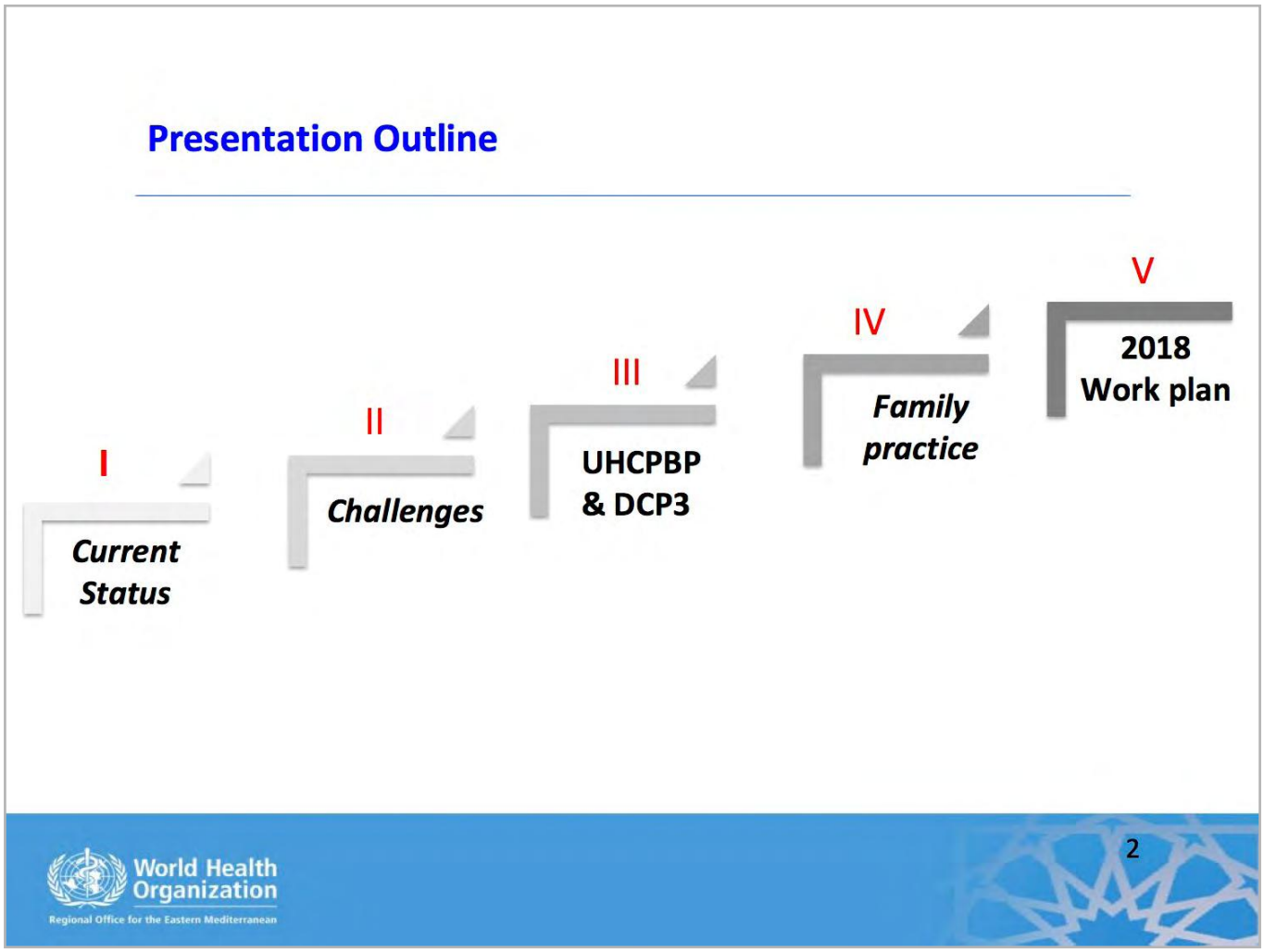
(Min. 00:18:45)

Hassan Salah: The presentation is about the role of the priority benefit package in the universal health coverage (UHC), or what we call it the “Universal Health Coverage Priority Benefit Package” (UHCPBP).



PRESENTATION OUTLINE

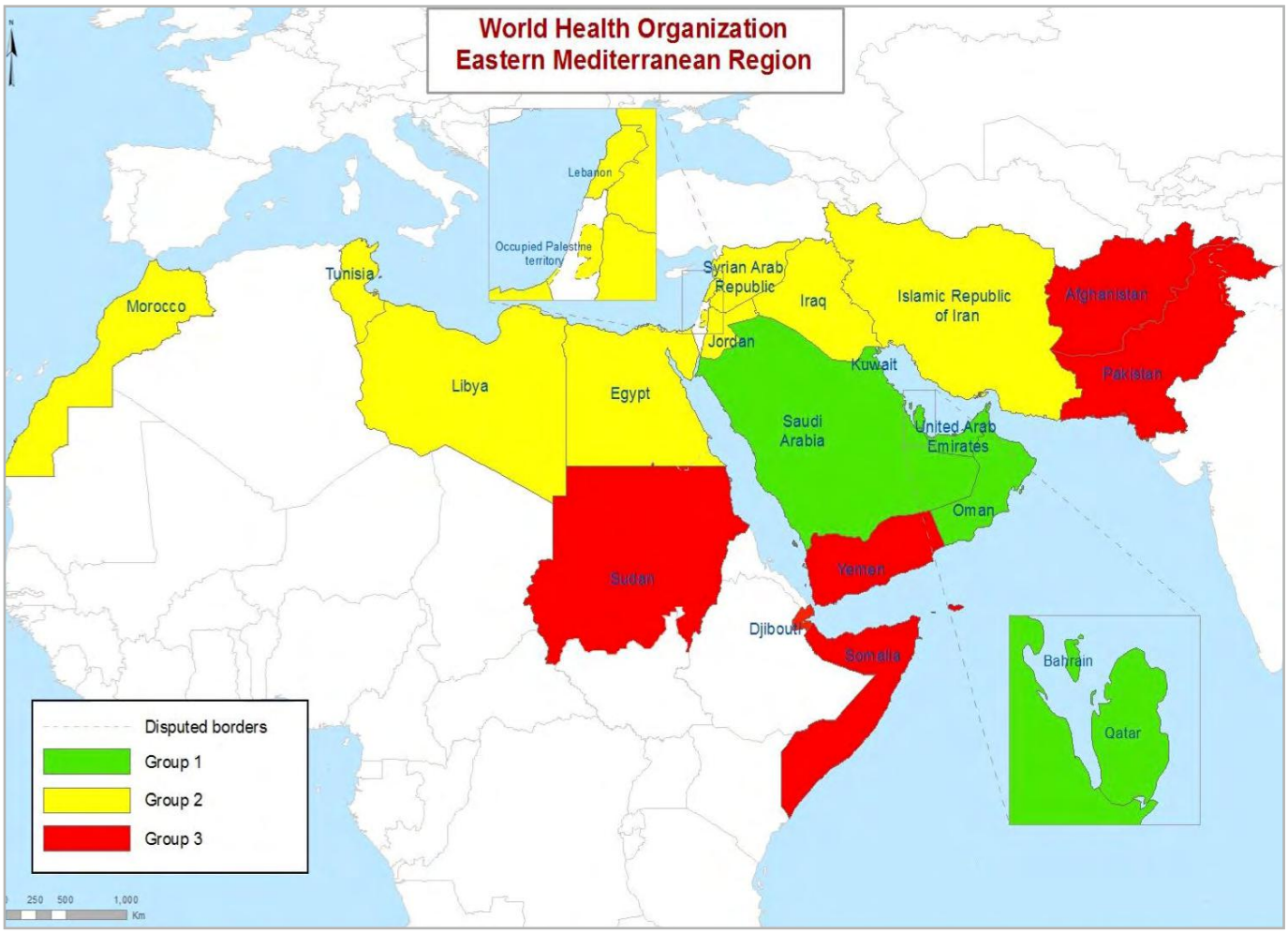
(Min. 00:19:25)

Hassan Salah: We are going to cover five topics. First, the current status of the service package in our region and, second, the challenges we are facing regarding its implementation. Then Dr. Awad Mataria is going to cover the UHCPBP and additions to the Disease Control Priority 3 (DCP3). And then I will follow explaining the “family praxis” as a model that we are using in order to maintain the quality of the essential health service package in our region. And I will end with our work plan for 2018.

HEALTH IN THE SDG ERA

(Min. 00:19:57)

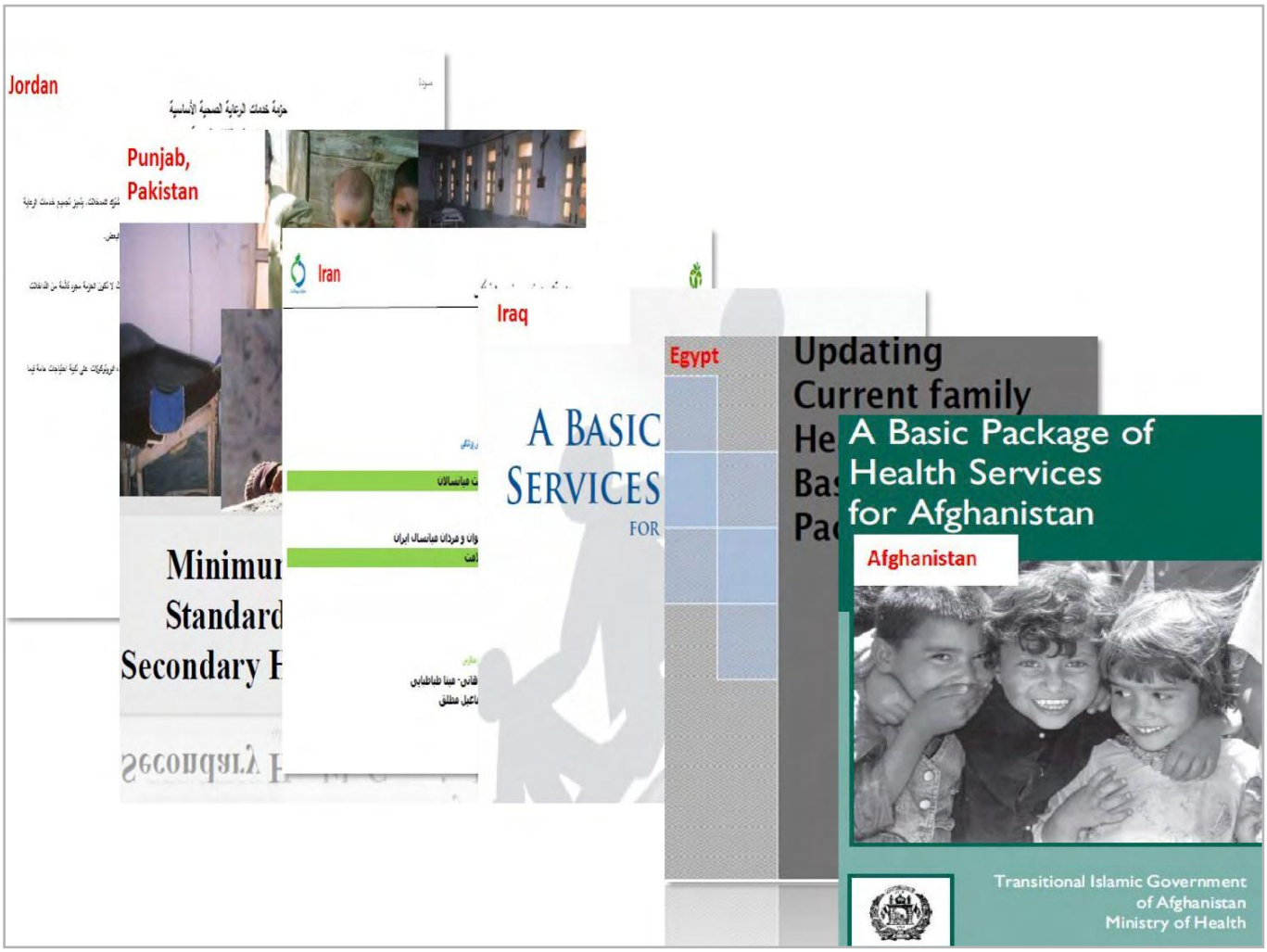
Hassan Salah: I am sure that all of us are familiar with the 'Sustainable Development Goals' and in particular goal 3.8, which is talking about quality essential health care services. So what is the situation of the essential health care services or package in our region, the Eastern Mediterranean Region?



EASTERN MEDITERRANEAN REGION

(Min. 00:20:20)

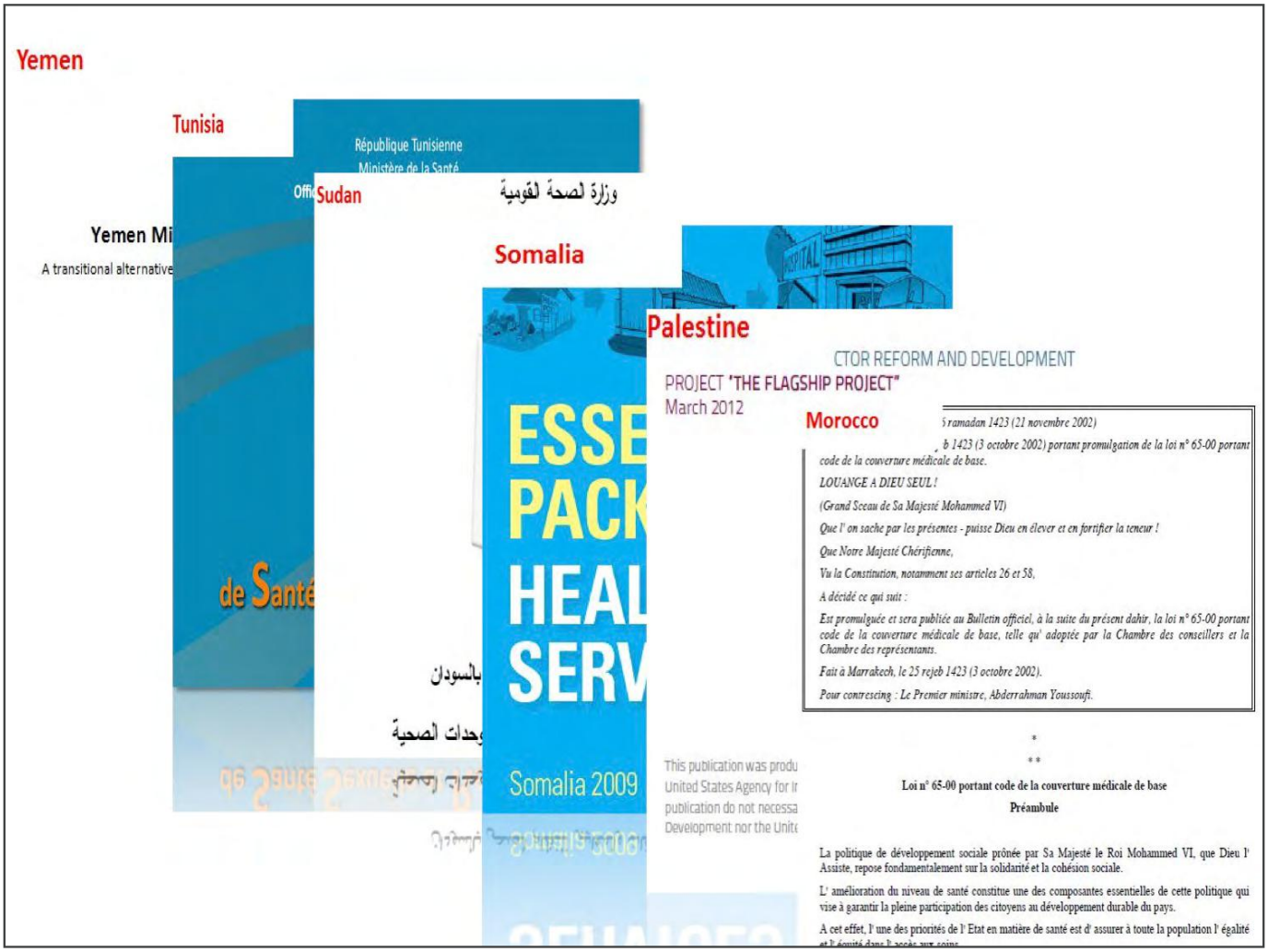
Hassan Salah: Our region includes 22 countries, starting from the west with Morocco and reaching to the east including Republic of Iraq, Afghanistan and Pakistan. As I mentioned it includes a total of 22 countries and a total population of around 0.6 billion. And there are six high-income countries, which are the ones marked in green, and sometimes we call them group 1. There are ten middle-income countries, marked in yellow. And the low-income countries are sometimes called group 3 and these include Afghanistan, Pakistan, Yemen, Somalia, Djibouti and Sudan.



EASTERN MEDITERRANEAN REGION

(Min. 00:21:05)

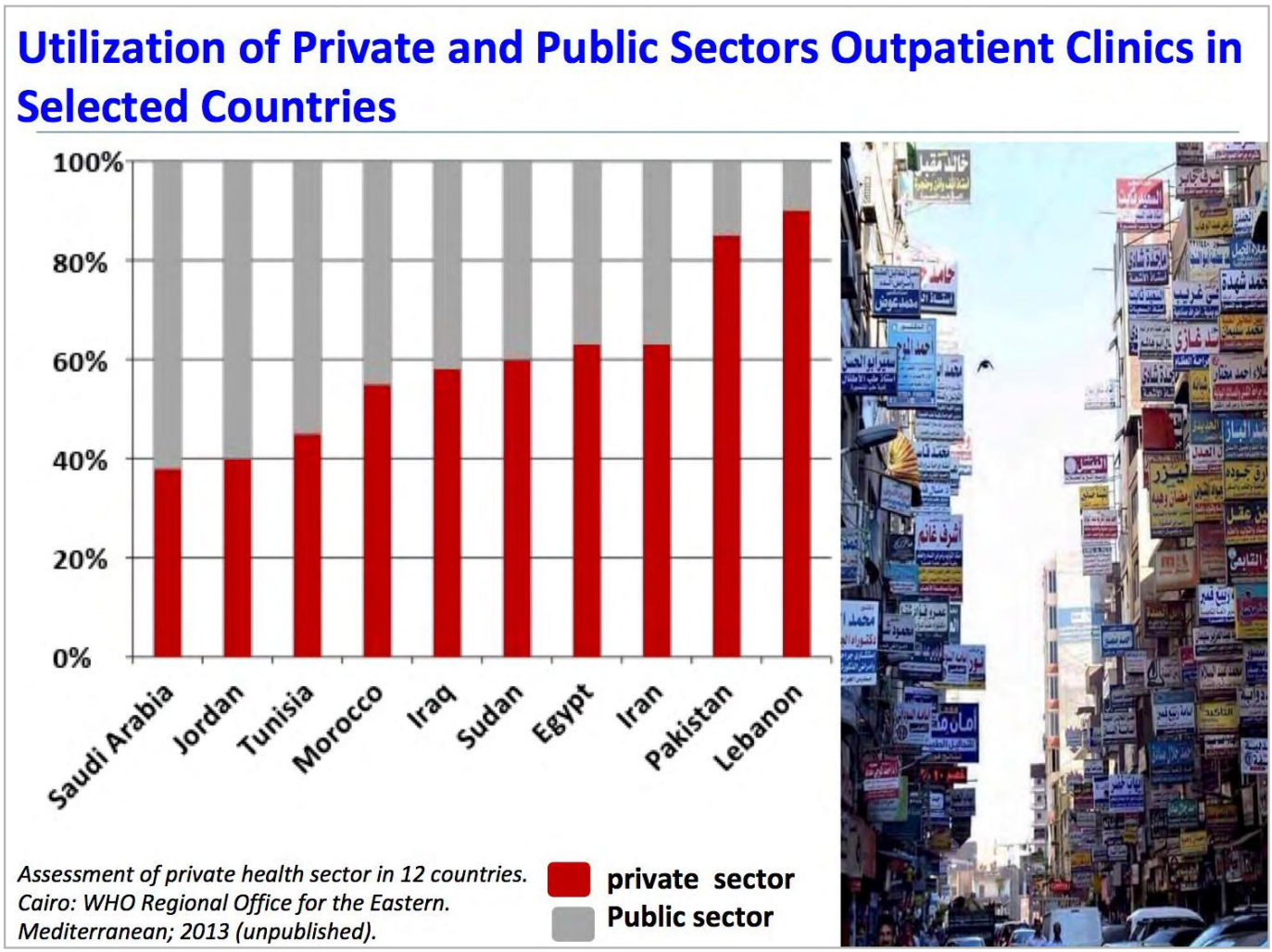
Hassan Salah: All the countries in our region, without exception, maybe only Somalia, have a good network of public primary health care facilities. And all of them have good documents about essential health service packages.



EASTERN MEDITERRANEAN REGION

(Min. 00:21:25)

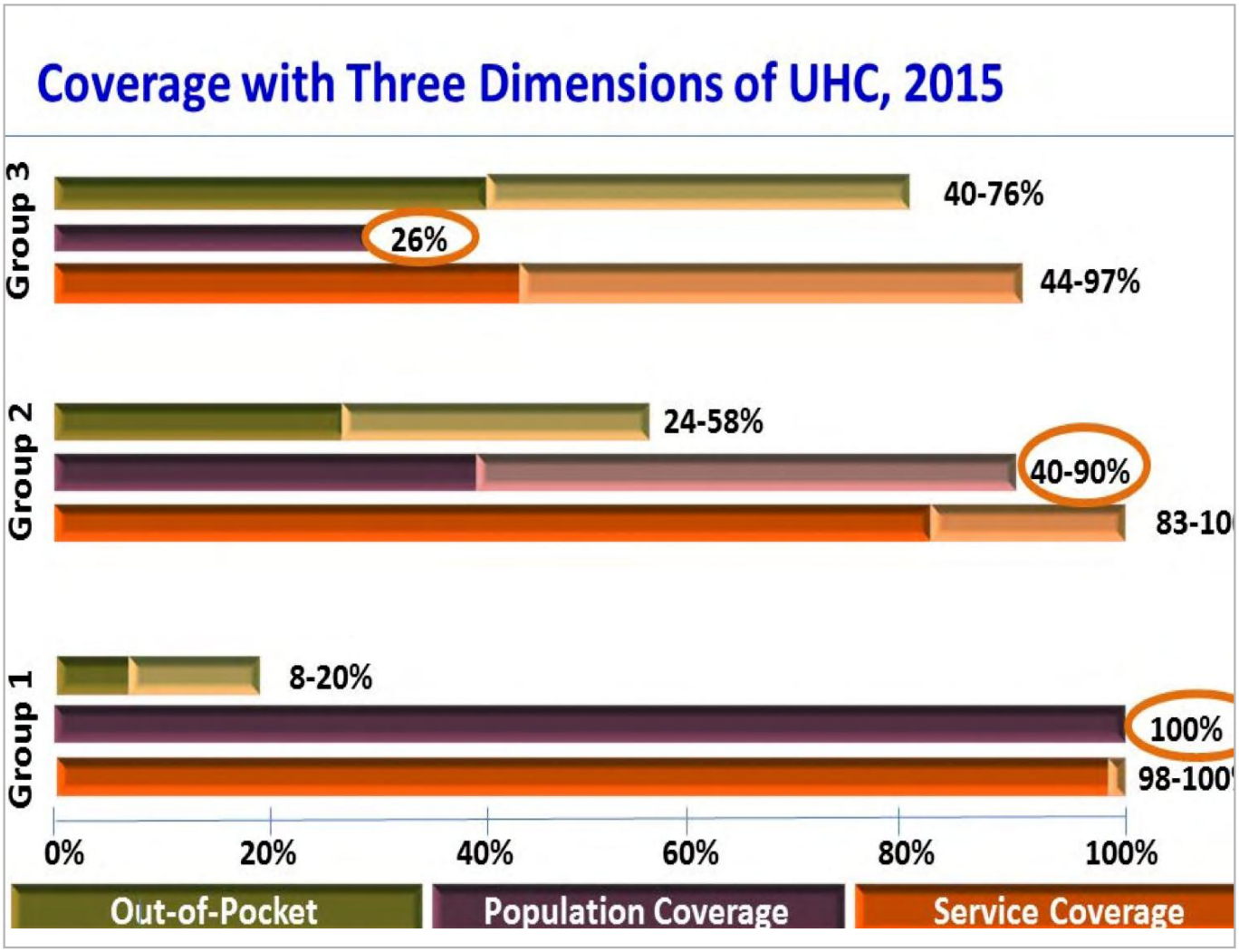
Hassan Salah: But the problem is not about the documents itself. The problem in our region is the quality of implementing the content of these documents for the essential health service package. In most of the countries of our region there is limited quality of the essential health services provided by the public sector.



UTILIZATION OF OUTPATIENT CLINICS

(Min. 00:21:47)

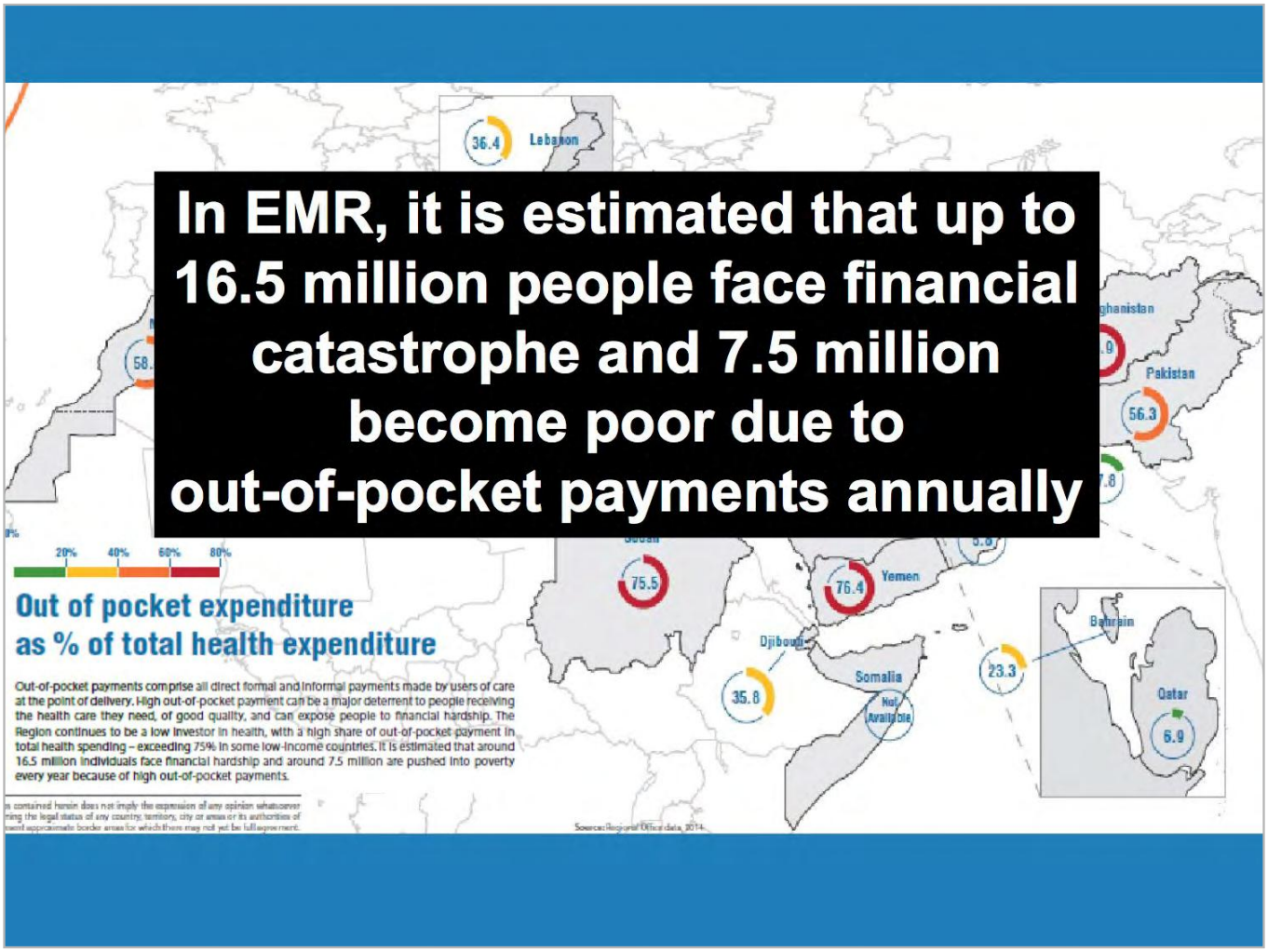
Hassan Salah: This actually leads to the fact that the private health sector is taking the lead in delivering the service. On average around 70% of the services are provided by the private health sector. There is a very high out-of-pocket expenditure, of course.



COVERAGE

(Min. 00:22:02)

Hassan Salah: in addition, there is very low population coverage, mainly in group 3. I am talking here about Pakistan, Afghanistan, Somalia, Sudan and Djibouti where the population coverage is about 26% by the public sector primary care facilities.



COVERAGE

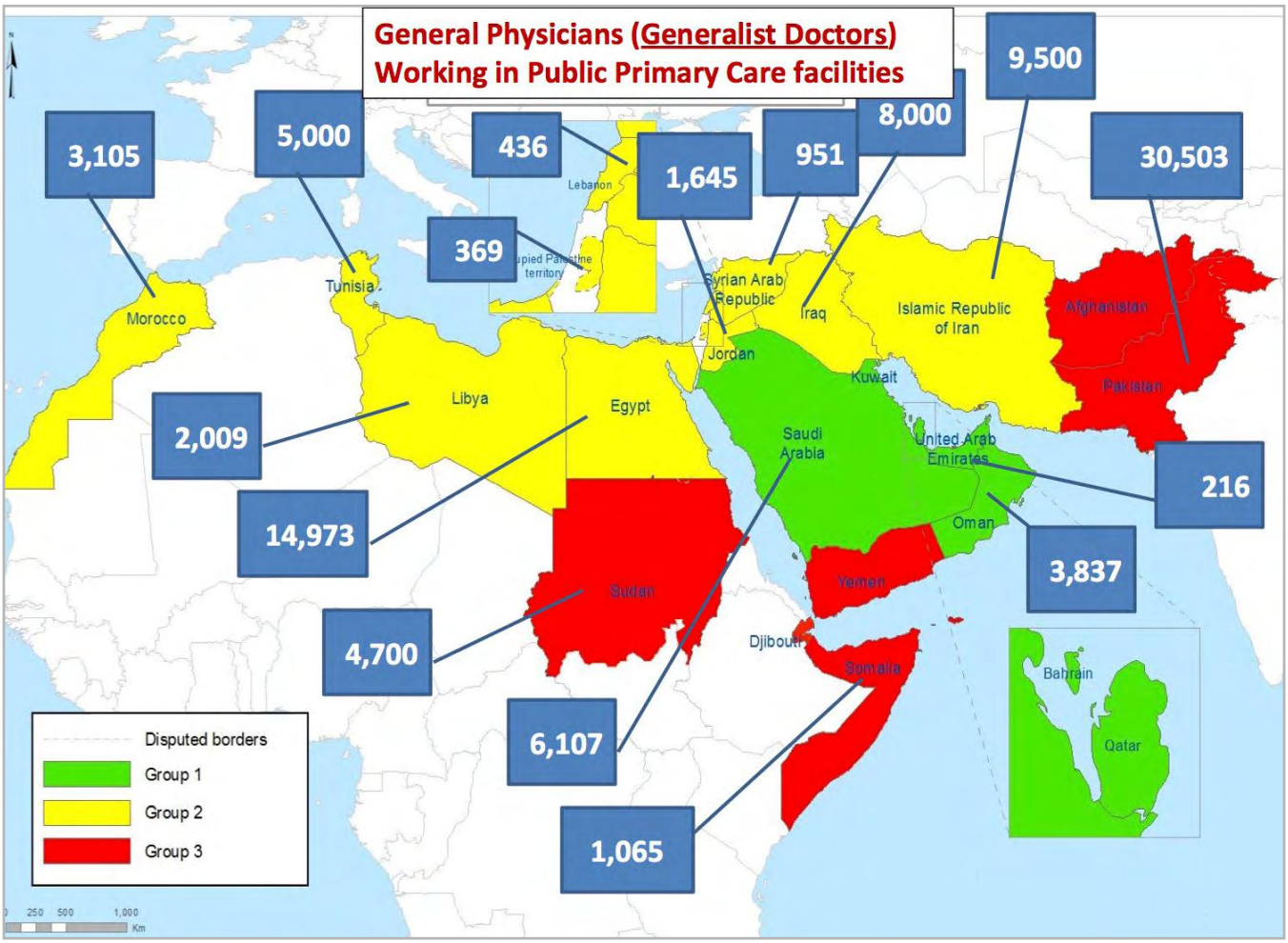
(Min. 00:22:20)

Hassan Salah: On average in the region we have 7.5 million people per year who become poor due to high out-of-pocket expenditures, mainly in the private health sector. So the question is: why do we have limited quality of the services in most of the countries of primary care in the public sector in our region? There are four main reasons.

LACK OF QUALITY INDICATORS

(Min. 00:22:49)

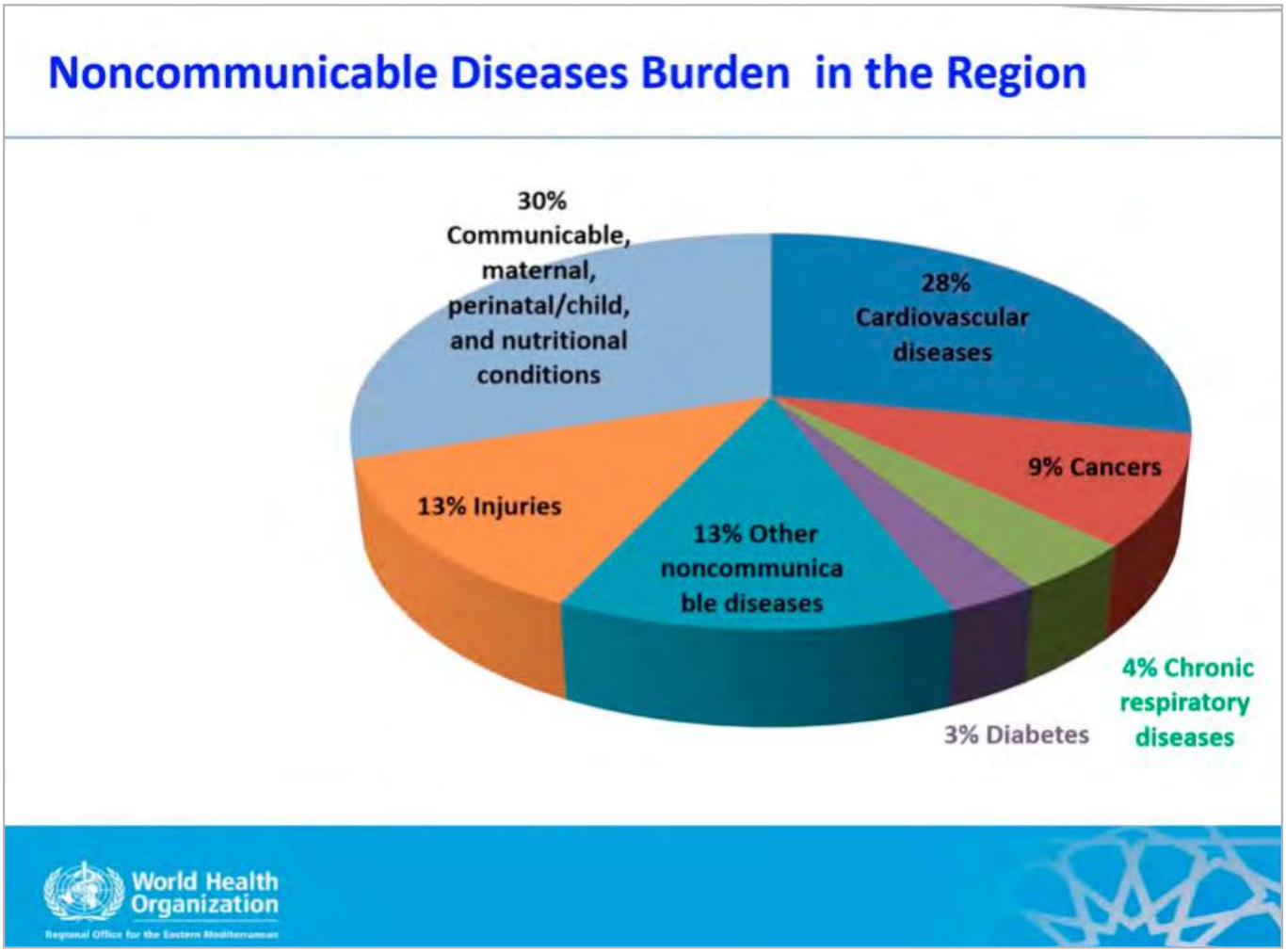
Hassan Salah: The first reason is that we don't have clear quality indicators and quality measures at the public primary health care facilities. This is the first one.



GENERAL PHYSICIANS

(Min. 00:22:58)

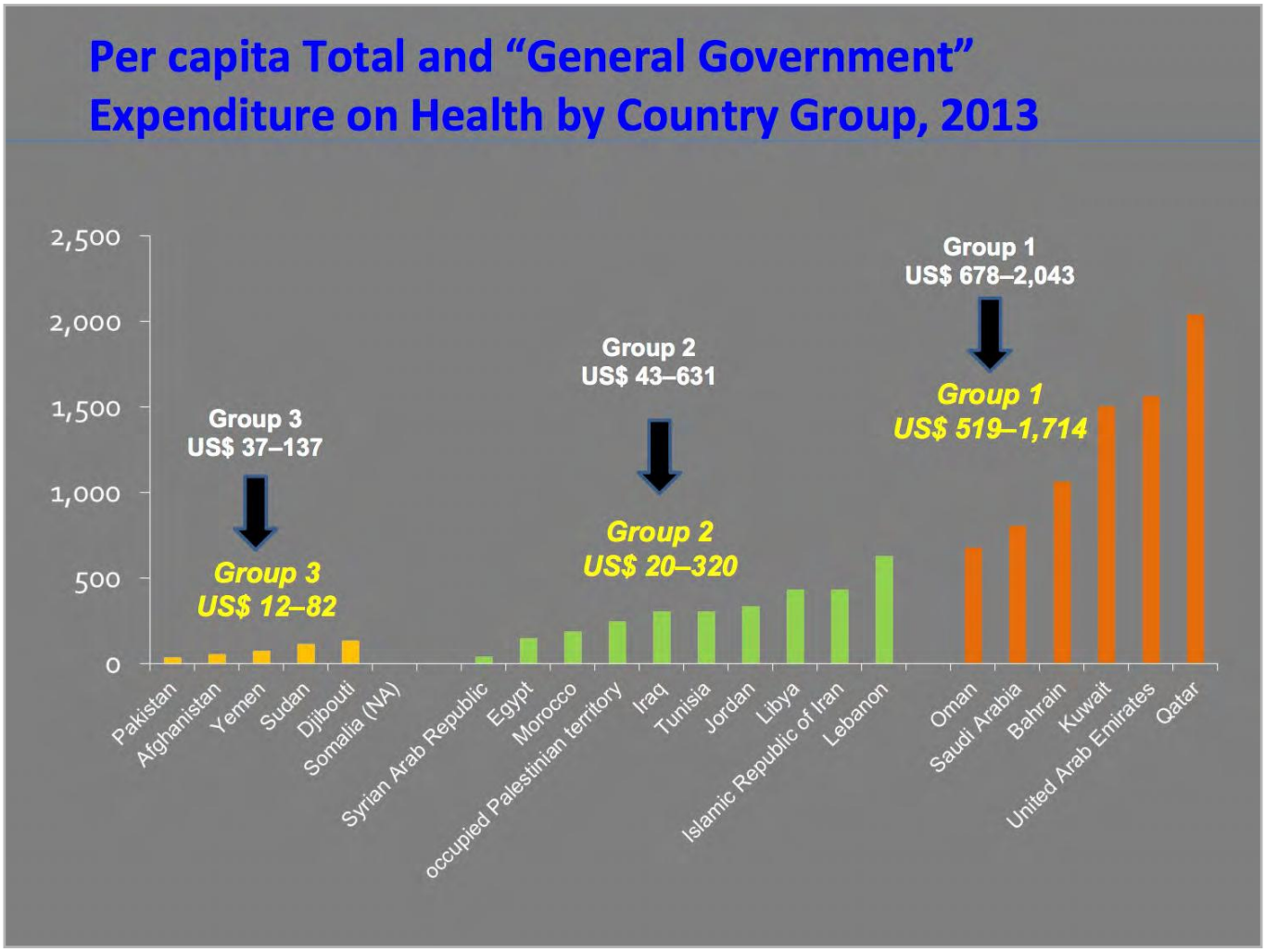
Hassan Salah: The second one is that the providers at the primary health care facilities, the physicians, are general physicians. They are not general practitioners and they are not family physicians. They graduated from medical school without any further specialty. We are talking about 93% of the primary health care facilities in our region. When we conducted an assessment, we found that these physicians they did not receive a single medical training for three years.



NON-COMMUNICABLE DISEASES

(Min. 00:23:30)

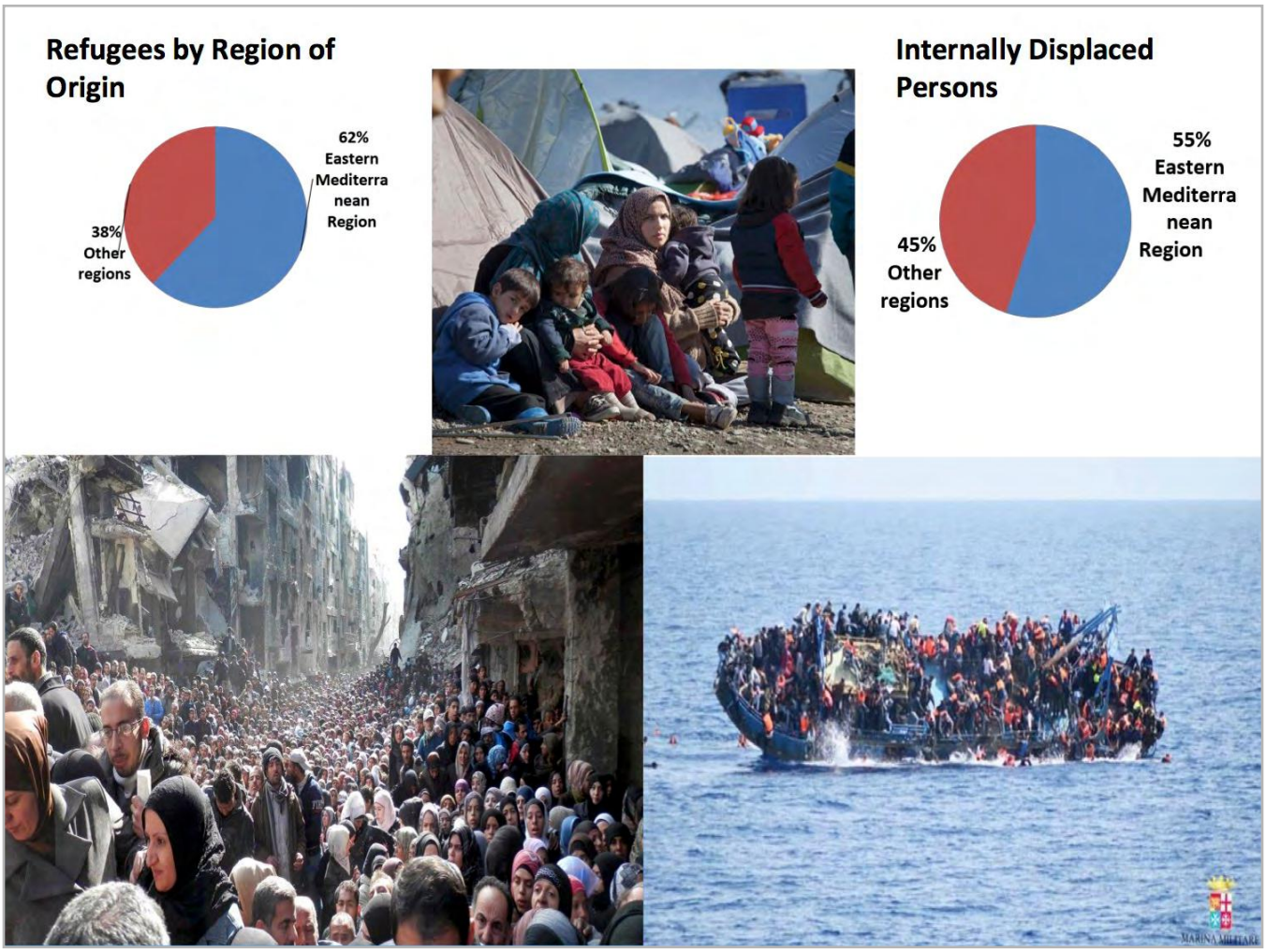
Hassan Salah: The third reason is related to the non-communicable diseases. Non- communicable diseases are already part of the core of the essential heath service package in all countries in the region. When we conducted the assessment, we found that only 20% of the primary health care facilities provide a comprehensive approach when dealing with non-communicable diseases. We have to take into consideration that 70% of the cases of mortality in the Eastern Mediterranean region are related to non-communicable diseases.



GENERAL EXPENDITURE ON HEALTH

(Min. 00:24:06)

Hassan Salah: And a very important factor, and this is the last one, is related to financing. Most of the budget of the Ministry of Health is directed to the curative care, to the hospitals and to the tertiary care. A very limited amount of the budget is directed to primary health care. This is the situation in one third of the countries in our region. What about the other two thirds?



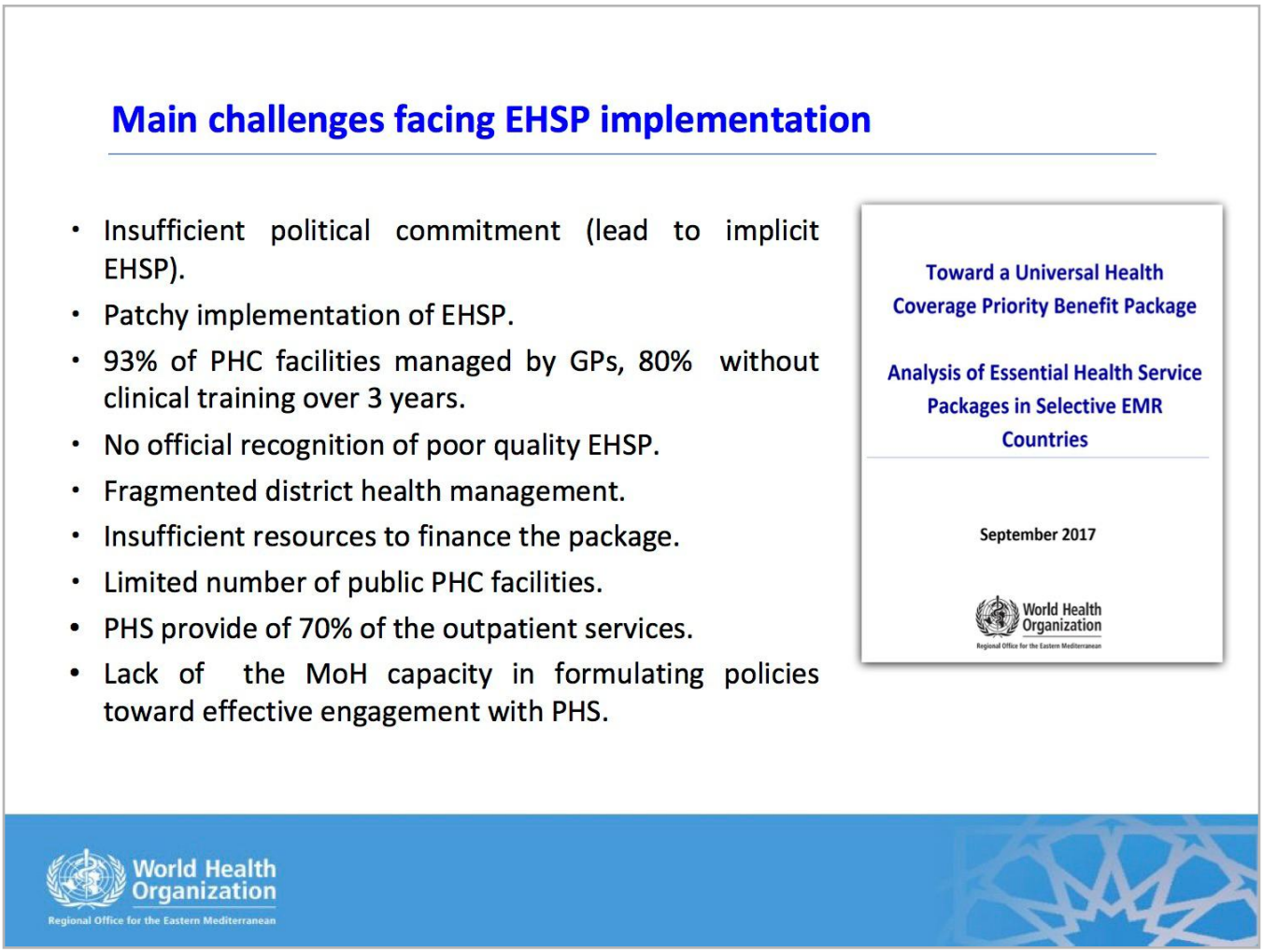
EMERGENCY SITUATIONS

(Min. 00:24:29)

Hassan Salah: The other two thirds of our countries are under an emergency situation. These countries include 62% of the global refugees. In 2015/2016 60% of the global health workers who have been killed or injured are from our region, from the Eastern Mediterranean region. This leads to a drop in the health work force by 50% in Syria. Also 80% of the nurses in Libya left the country because they are expatriates.

(Min. 00:25:09)

Hassan Salah: And around 50% of the population, both in Yemen and in Somalia, don't have access to the essential health services. All of these issues have a serious negative impact on the delivery and the quality of essential health service package in our region.



MAIN CHALLENGES

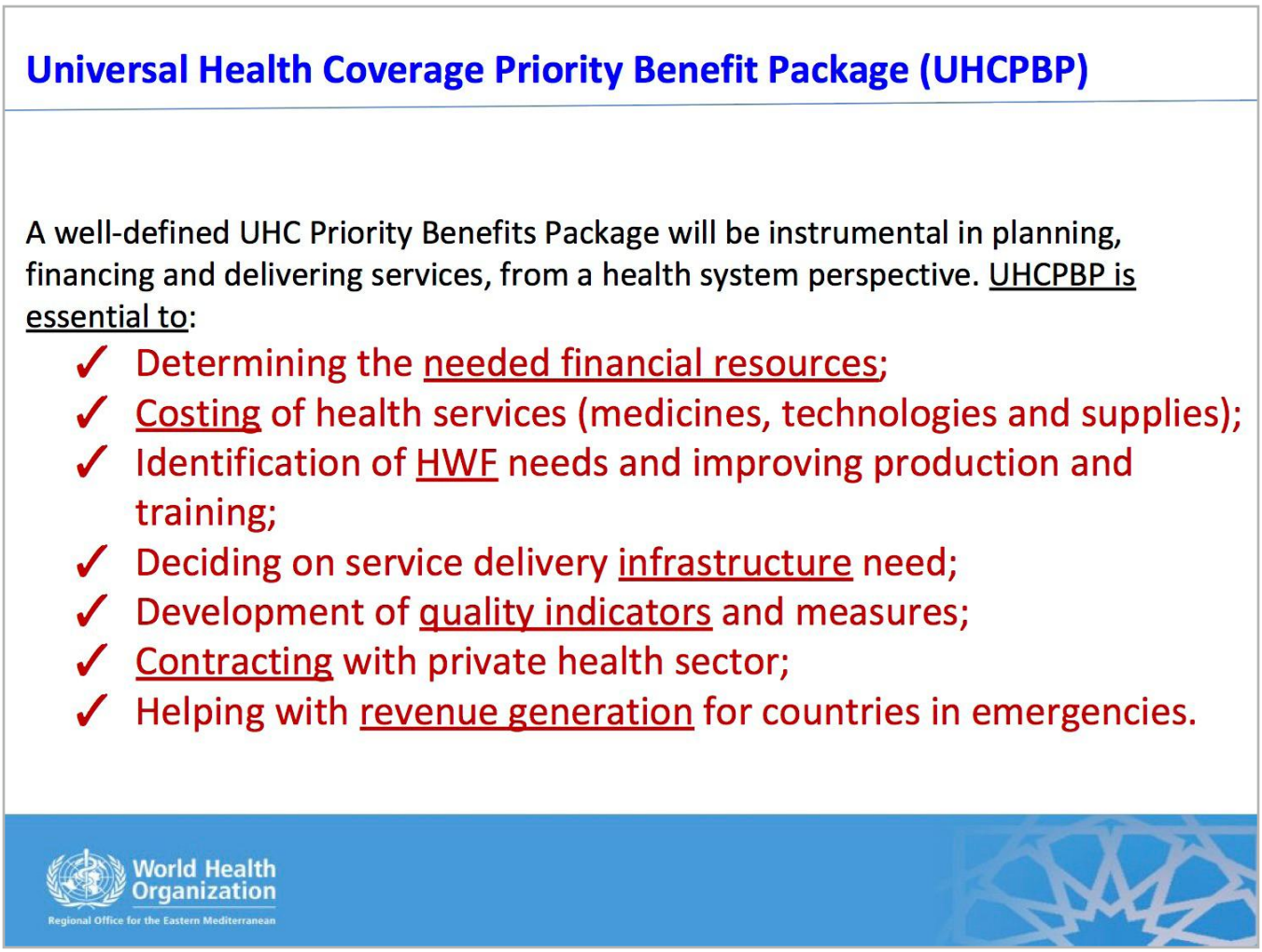
(Min. 00:25:29)

Hassan Salah: Last year, in September 2017, we conducted an assessment on the essential health service package in a number of countries. We wanted to look at what exactly were the reasons of the deterioration of the packages in these countries. The main reason is that there is insufficient political commitment. There is an essential health care service package but it is an implicit one. It is not an explicit essential health care service package. In addition, there is a patchy implementation of the package, and I already gave you the example of the non- communicable diseases. Most of the physicians are generalized physicians with very limited training. And I mean the training here is a clinical training. And, of course, there is no official recognition of the poor quality of the package and it became kind of a routine to have this poor quality of the packages.

The district health management plays a major role in maintaining the quality of the service and it is fragmented in most of the districts in the region. In addition, of course, there are insufficient financial resources and there is a limited number of public primary health care facilities compared to the total population of the countries. And this is the situation in most of the countries in our region. This, of course, leads to the private health sector taking the lead and delivering 70% of the services. It is also important to mention that the staff working at the Ministries of Health is lacking capacity to formulate an effective engagement with the private health sector. This is a very important issue.

(Min. 00:27:17)

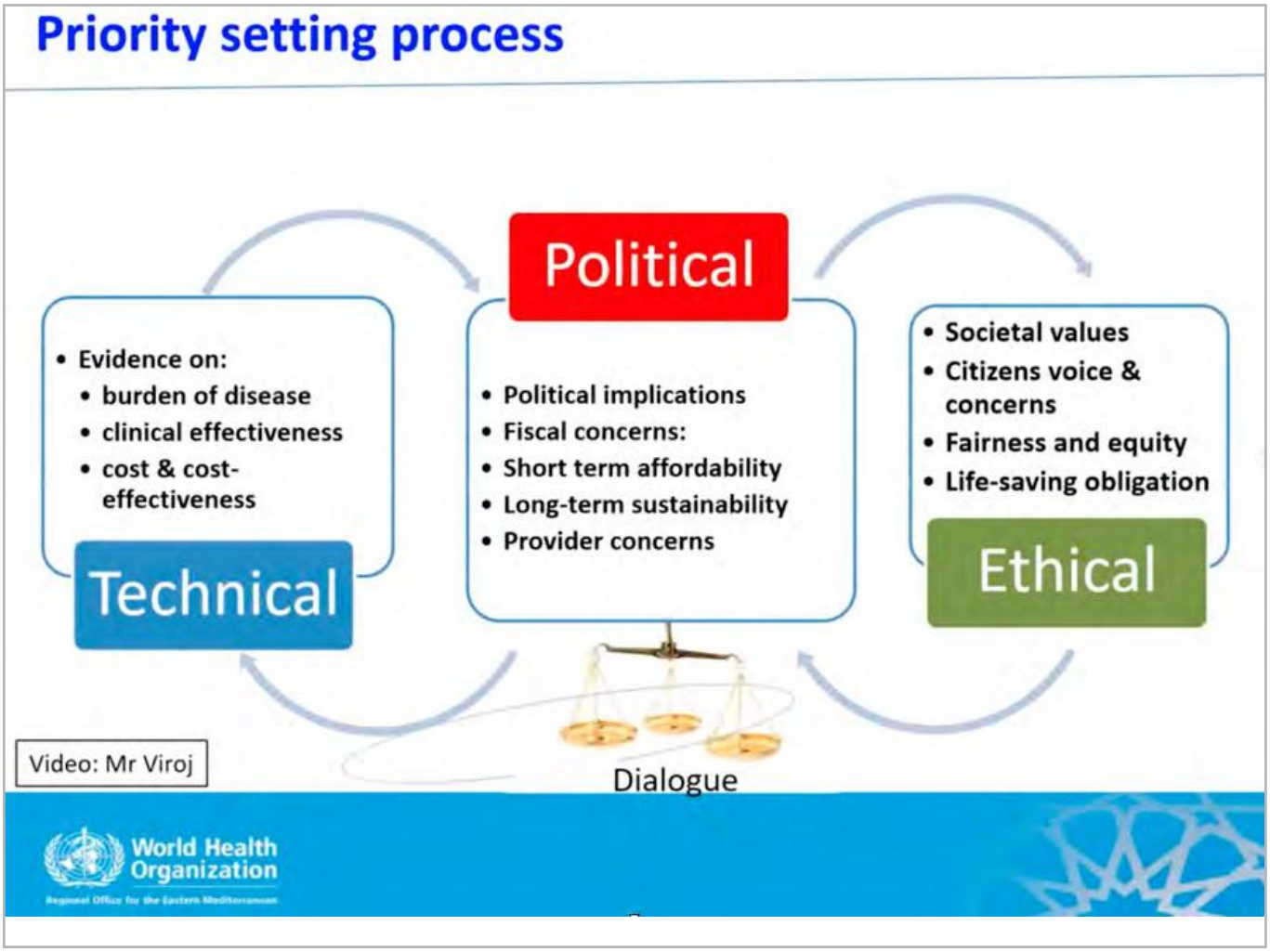
Hassan Salah: The question is: do we need a universal health coverage priority benefit package?



UNIVERSAL HEALTH COVERAGE PRIORITY BENEFIT PACKAGE

(Min. 00:27:20)

Hassan Salah: The answer is yes, definitely, we need that. Why? Because the availability of such a package, the UHCPBP, will help us identify what we need for the health work force. That is going to help us to identify the infrastructure and costing of services. In addition, we are going to identify the quality indicators and the quality measures and it will make it very easy for us to contract according to the contents of this package with the private health sector. And of course, we are going to identify the needed financial resources. Talking about the countries in emergency situation it is going to be considered as revenue generation for these countries.



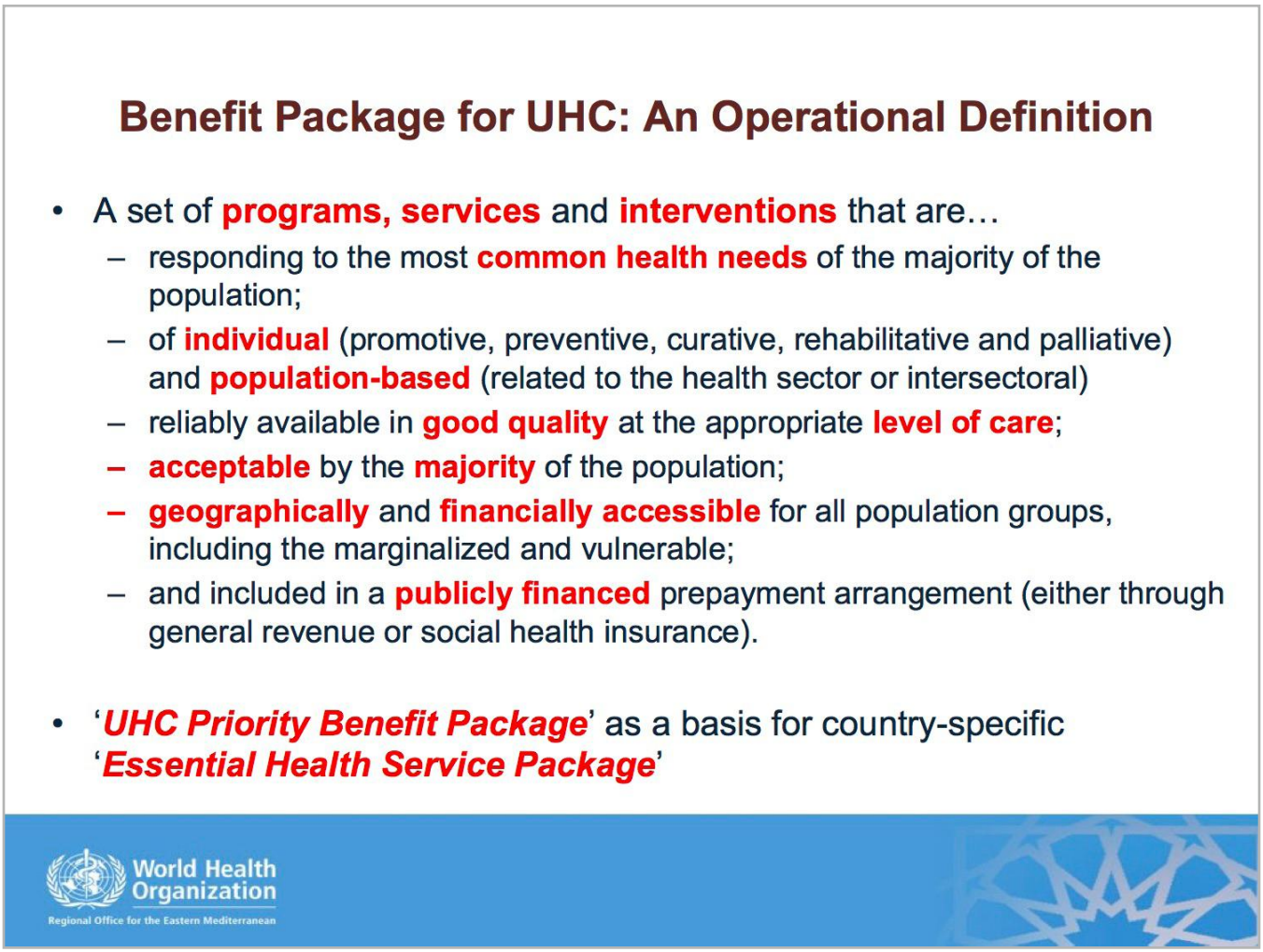
PRIORITY SETTING PROCESS

(Min. 00:28:06)

Hassan Salah: We also have to take into consideration that the delivery of the package is not an easy task. Actually, it works in three directions and these three directions are interacting with each other. I mean that there is a technical a political and an ethical direction. So simply we are going to identify who is going to make use of the service, when, where and how much it is going to cost us. And regarding this aspect I would like to share with you the model of Thailand. This is about dialysis. Dialysis was actually not part of their package in Thailand. And in a short video from Mr. Viroj, who leads this issue about the essential package in Thailand, he tells us about the political and the cultural background about dialysis and the reason why they included it in the essential package in Thailand.

(Video Minute 00:29:14)

Mr. Viroj: Thailand has expanded dialysis into the UHC scheme in 2007/2008. Initially dialysis was not included in the package because it was too costly and the health system in 2001 was not ready to provide universal access to dialysis for all citizens. Therefore, we delayed the implementation, similar to ARV (Anti-viral drugs). Initially the package excluded these two interventions although both are lifesaving. IHPP, the agency we work with, consistently made inquiry regarding the pain and the suffering and the cost of dialysis and how much the patients paid. And we found that the households were suffering because they have to borrow money, sale their cattle, their land and their assets and they die with a huge debt and the sons and daughters had to repay those debts. So this is a real pain. At the same time IHPP has uncovered that dialysis is not cost-effective at all. We measured this by incremental cost-effectiveness ratio and it has gone beyond four, four times of our TRI per one quality year of life gained. We used only one TRI as a benchmark and this has gone up about three to four times, which is beyond the benchmark. Therefore, this intervention either dialysis or chemo or kidney transplantation are not cost-effective. But the Prime Minister and the Minister of Health had decided to include peritoneal dialysis into the benefit package, despite the fact that it is not cost-effective but because it is catastrophic to the household. It ruins the financial well-being and livelihood of the household and the patients die leaving a great debt behind. In addition, it is quite unequal because two other schemes, which are the common employee scheme and the social health scheme also cover it fully. Therefore, why does this scheme not cover it? And the budget impact is so great. So this means that cost-effectiveness does not always have to be the single criteria of making a decision. We also have to look at capacity and catastrophic impoverishment of the household. We introduced first a peritoneal dialysis policy because PD is acceptable because the patient can manage it at home.



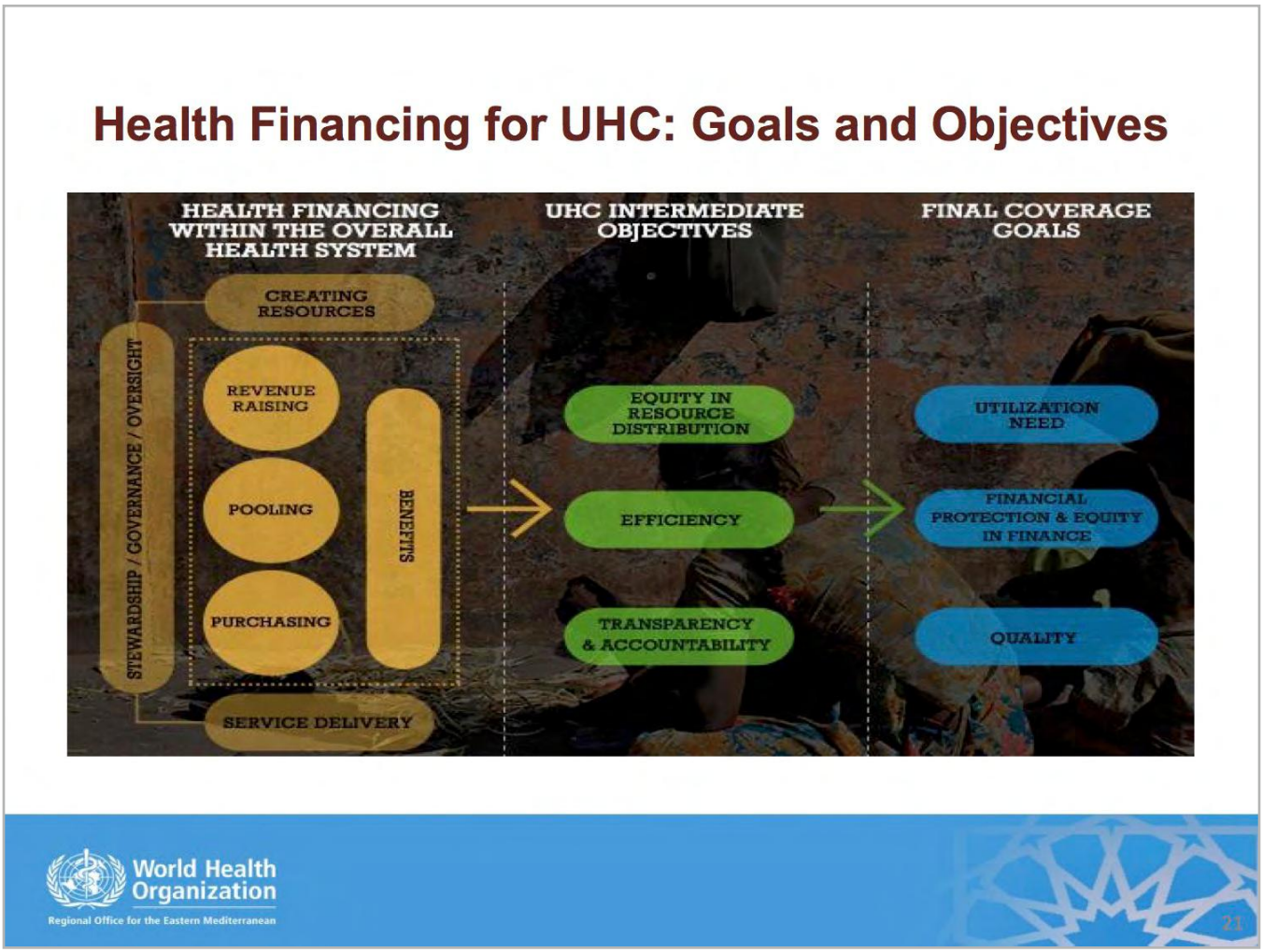
BENEFIT PACKAGE FOR UHC

(Min. 00:33:43)

Awad Mataria: I will take it from where my colleague Dr. Hassan Salah ended his slides. He was talking about different criteria that we can use in order to define a benefit package for universal health coverage for the region. So when we tried to go about advising our countries on defining their own packages and to prioritize a set of interventions, we wanted to come up with an operational definition of what we need for a benefit package for universal health coverage. And what you see on the slide are the criteria that we put together in order to define that package that we would like our countries to develop. We defined it as a set of programs, services and interventions that are responding, first of all, to the most common health needs of the majority of the population. We would like that this package responds to the major burden of diseases

in the countries. We are cautious that this should not only include individual interventions but also population based interventions. We wanted to look at individual interventions of promoting, preventive and curative and rehabilitative nature but also with regard to population interventions we wanted to include things that are within the health sector and things that are beyond the health sector through inter-sectorial collaborations.

And we would also like that these interventions have good quality in order to impact the health of the population. And we would like to specify at which level of care these interventions would be delivered, whether it is at the primary health care level, the secondary level or tertiary level. Another criteria is related to the accessibility of the services within the package by the majority of the population and we also would like these to be accessible geographically and financially for the whole population. My colleague Hassan referred to the problem of refugees and internally displaced people (IDP) in the region. We would like them to have access as well to those packages. Last but not least the importance of including these interventions and such interventions in publicly financed pre-payment arrangements, whether it is financed through general government revenue or in the form of social health insurance. So what we are trying to do, at the regional level at WHO, is to try to come up with a set of interventions that would constitute such a priority benefit package for universal coverage that we are presenting to our members and countries in the region in order to adapt them and to develop their own essential health service package. We are cautious that whatever we would like to talk about in regard to benefit packages, other policies or interventions that these should be done from the perspective of moving towards universal health coverage.



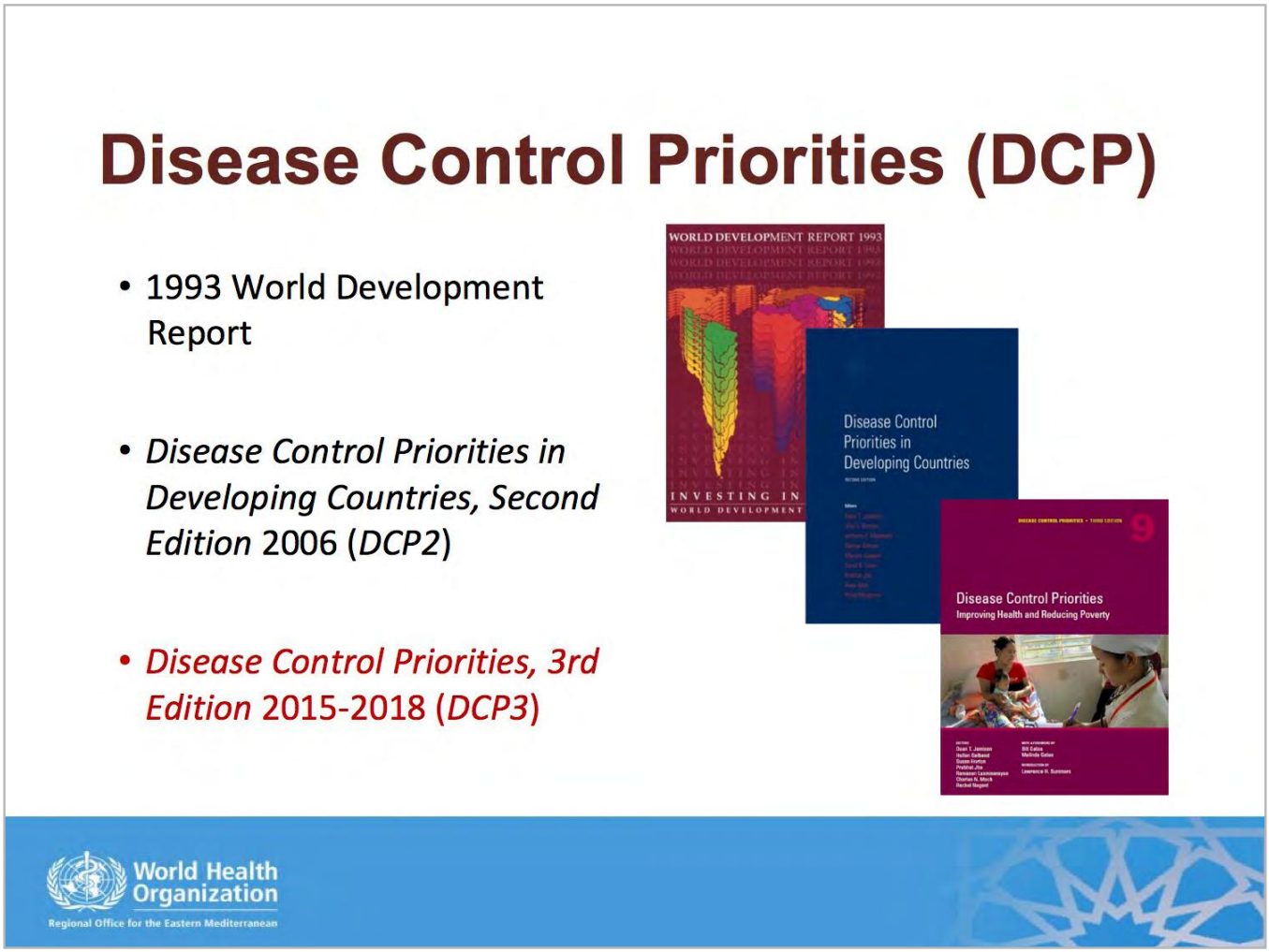
HEALTH FINANCING FOR UHC

(Min. 00:36:40)

Awad Mataria: I am pretty sure that you have seen this framework that I am showing on my screen, which shows the final objectives and goals and the intermediate objectives of universal health coverage (UHC) and the way we are framing them is from a health-financing point of view. So whatever we would like to do in the health system in order to move to UHC should lead to reducing the gap between utilization and need, should enhance financial protection and should improve the quality of health services. I am showing this to tell you that the spirit of developing the benefit package is coming from its contribution to these goals. For instance, with regard to reducing the gap between utilization and need, the fact that a package would be presented as a legal right for people. So it is something that everyone in the society should have access to. The

simple fact that it is a legal right of universal nature and that it is not dependent on nationality, on residency status or whether the person is contributing or not, that by itself would help to reduce the gap between utilization and need. We are also paying attention to including in the benefit package interventions that are covering a variety of conditions and diseases at the country level based on the burden of disease but also based on the cost-effectiveness of these interventions.

At the same time prioritizing the vulnerable groups and looking at the needs of people who are in most need, I refer to the refugees and the internally displaced people but also to the expatriate population in our Gulf Cooperation Council countries. These are the high-income countries in the region. Again, that would result in reducing the gap between utilization and need. Another link between the package and this ultimate goal of universal health coverage is that when we develop a package, and present it in a clear and simple way, making sure that the entitlements are understandable for the population, and sometimes possibly also including other criteria in the package such as reducing the indirect costs associated with accessing the interventions and the content of the package. That would by itself help addressing other barriers like demand side barriers for accessing health care services. The other ultimate goal is a financial protection goal. Again, in the package, as I mentioned, we are not just focusing on curative care. We are talking about promotive, preventive care and all dimensions of care. That by itself will contribute to keeping the population healthy and hence people won't need that much healthcare. That by itself will result in enhancing the goal of financial protection. But also, once the package is there and we look at how it is delivered and paid for, through a certain set of incentives, one can direct the behavior of the providers towards preventive care rather than just curative care, also by making sure that the high-cost services are part of this package. This by itself will also help enhancing the financial protection goal. And finally, the fact that we are having a package that could be presented to the Ministries of Health that would help them to have economies of scale and to enhance the effective purchasing of interventions by making savings regarding the purchase of interventions and hence minimizing the cost of delivering that package. By this we see that that package, having it be globally defined and then adapted to the local context, would really help progressing towards the different goals of universal health coverage.

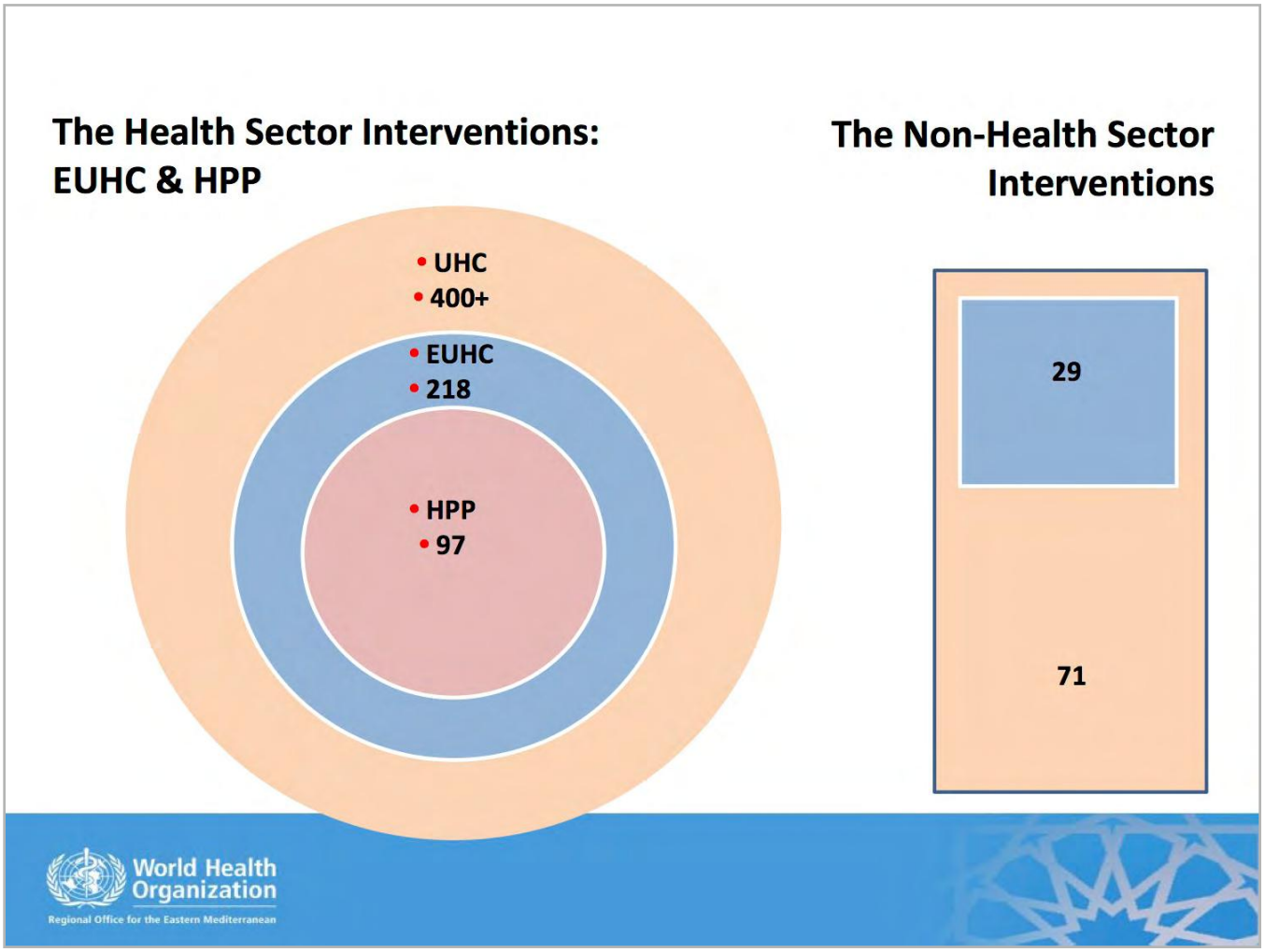


TOTAL SALES

(Min. 00:41:11)

Awad Mataria: We wanted to rely on something that existed and not start from scratch in order to help developing the benefit package for the region. We relied upon the evidence generated by the 'Disease Control Priorities Network' project. So briefly, this is a project that was started in 1993 as part of the World Development Report produced by the World Bank. It was the first attempt to define a set of interventions. Basically, it was meant for low-income countries to help them to achieve the Millennium Development Goals. In 2006 there has been another attempt to revise that set to make it more appealing and more relevant for a wider spectrum of countries. And just three years ago the third version of the Disease Control Priorities has started and it continues in the present. It is coming up with what is now known as DCP3, or 'Disease Control Priorities Third

Edition'. The Disease Control Priorities Third Edition consists of nine volumes, which are trying to address different health conditions or disease groups of relevance for the population.

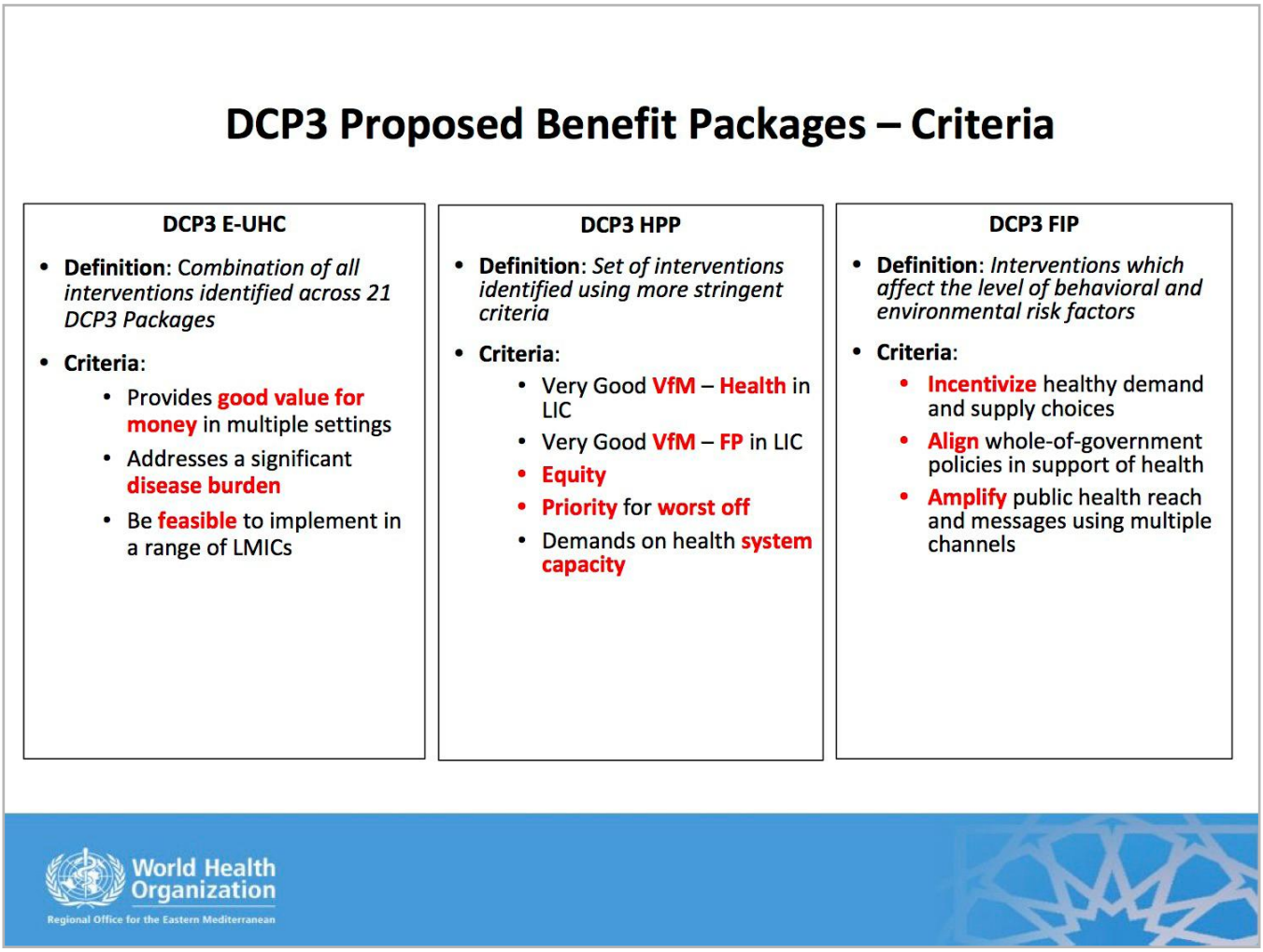


DISEASE CONTROL PRIORITIES

(Min. 00:42:29)

Awad Mataria: To explain to you briefly what the DCP3 has been trying to do, it is trying to look at the wider spectrum of interventions that are relevant primarily for low and middle-income countries but it is looking at all income levels. It is trying to do a systematic review of these interventions and coming up with definitions of what the interventions are which are proven to be cost-effective, affordable and feasible at different levels. They looked at more than four

hundred interventions. And from these interventions they came up with what is known now as the ‘Essential Universal Health Coverage Package’, which consists of 218 interventions based on a set of criteria that I will be showing to you. The authors on editors of the DCP3 also said that maybe for countries with some difficulties, like low-income countries, 218 interventions might be difficult to deliver. They defined a sub-set of those interventions which they call “Highest Priority Package” and it consists of 97 interventions. Beside those interventions that are relevant for the health sector, they looked at interventions beyond the health sector, which are primarily of inter-sectorial and fiscal nature. They defined 71 interventions or policies and from these a sub-set of 29 has been identified for low-income countries.

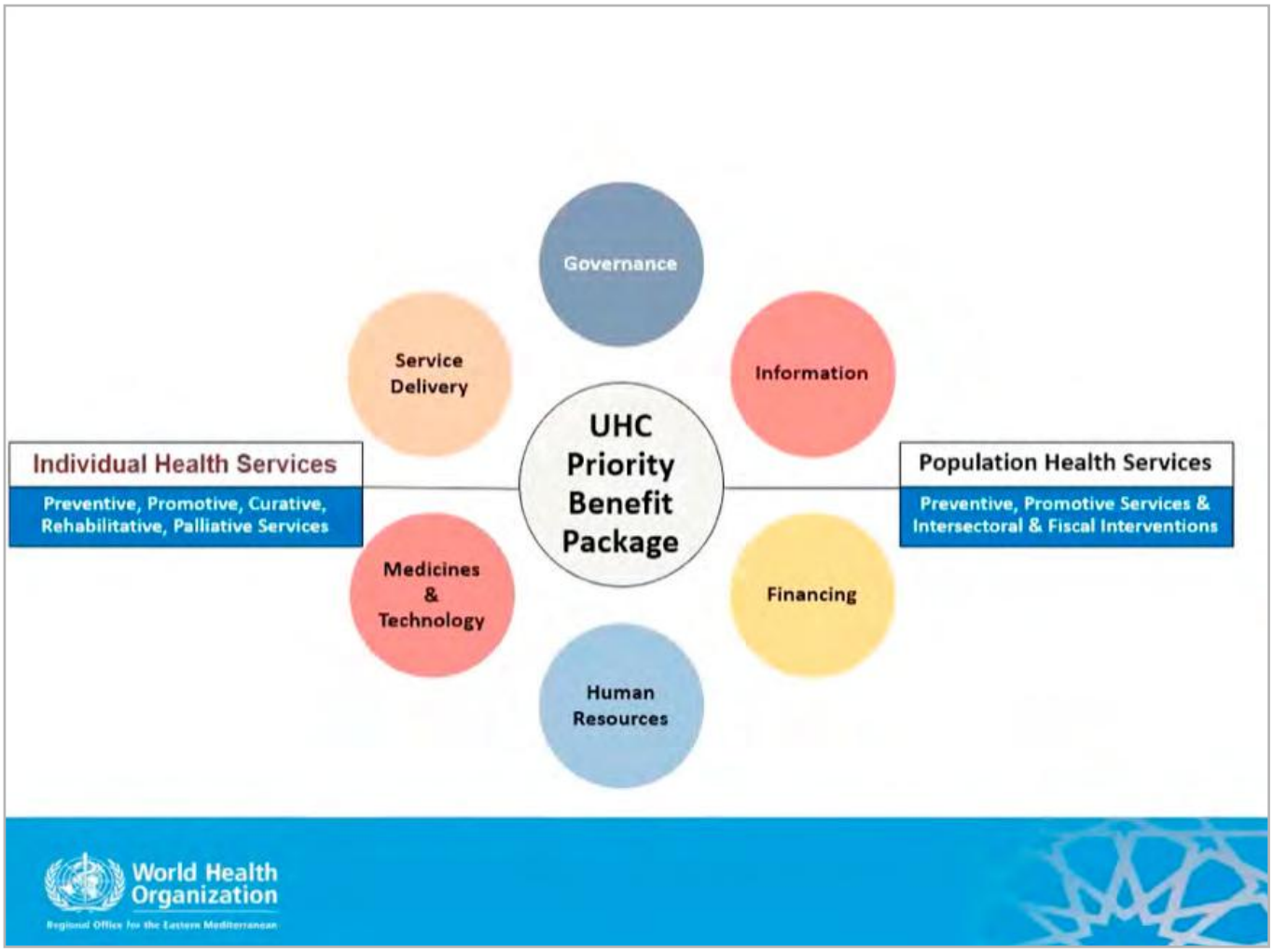


DCP3 PROPOSED BENEFITS PACKAGE

(Min. 00:43:57)

Awad Mataria: Here you see the different criteria that have been used for defining the 'Essential Universal Health Coverage Package' and the "Highest Priority Package" and the "Fiscal and Inter-sectorial Package". In terms of criteria they all refer to the value for money in terms of improving health, value for money in terms of enhancing financial protection and feasibility, as I mentioned, but also considering the capacity of the system. So moving from the 'Essential Universal Health Coverage Package' to the "Highest Priority Package" the main aspect is to become more stringent with regard to these criteria and moving from 218 to 97 interventions. I would like to say just a word on the "Fiscal and Inter-sectorial Package". These are looked at as policies that would incentivize individuals to change their demand and to impact on the supply choices of providers.

These are policies that help to align whole-of-government policies and inter-sectorial action for health and also to amplify the public health impact of different interventions.

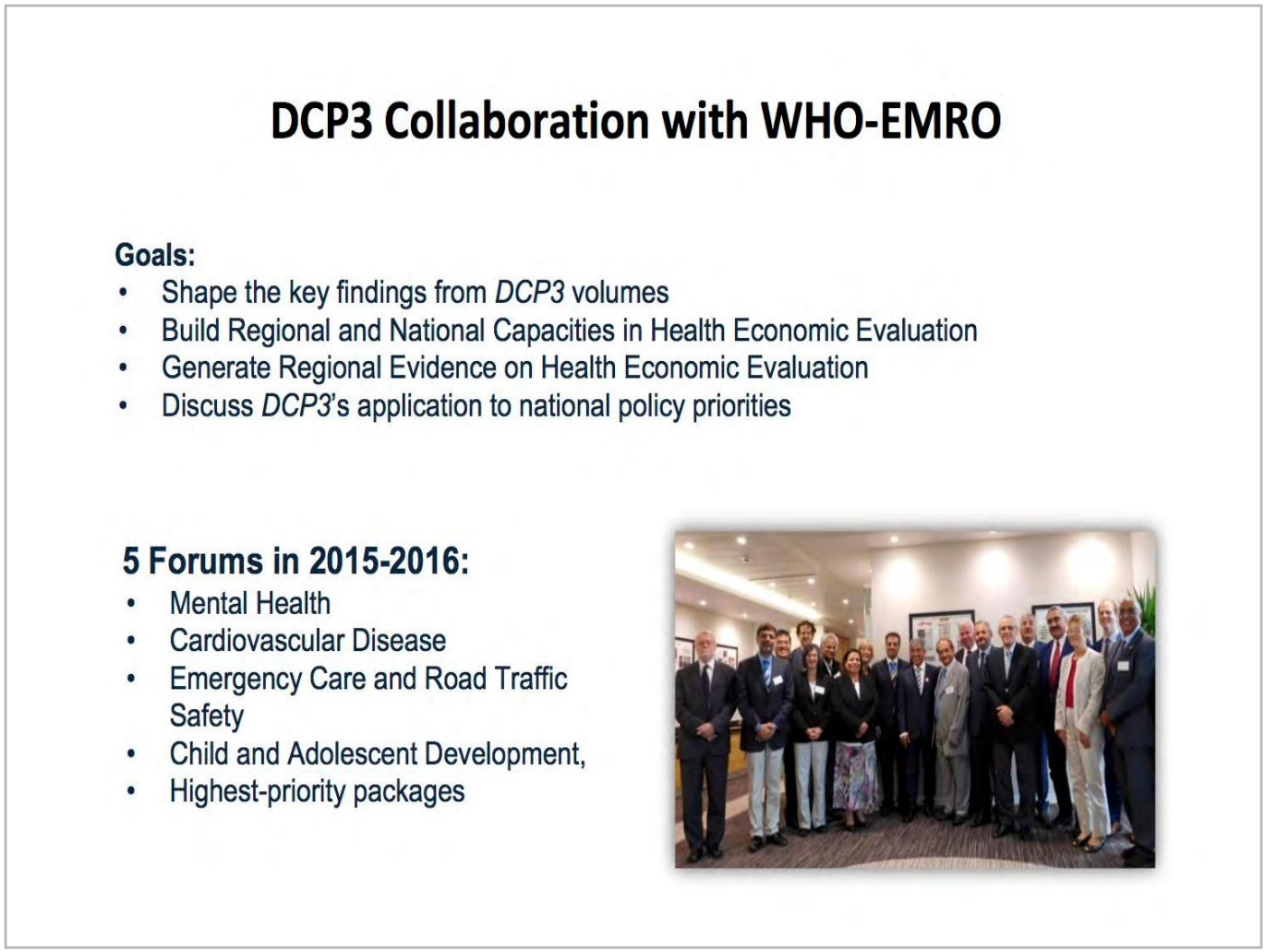


UHC PRIORITY BENEFIT PACKAGE

(Min. 00:45:08)

Awad Mataria: Now taking all of this from the global perspective, at the regional level what we thought is to bring these individual and population health services into what we would like to call 'Universal Health Coverage Priority Benefit Package'. And we are giving it a lot of attention. Once you know what we would like to deliver then this is how we can design the health system in terms of its governance, information, financing, human resources, medicines and technologies

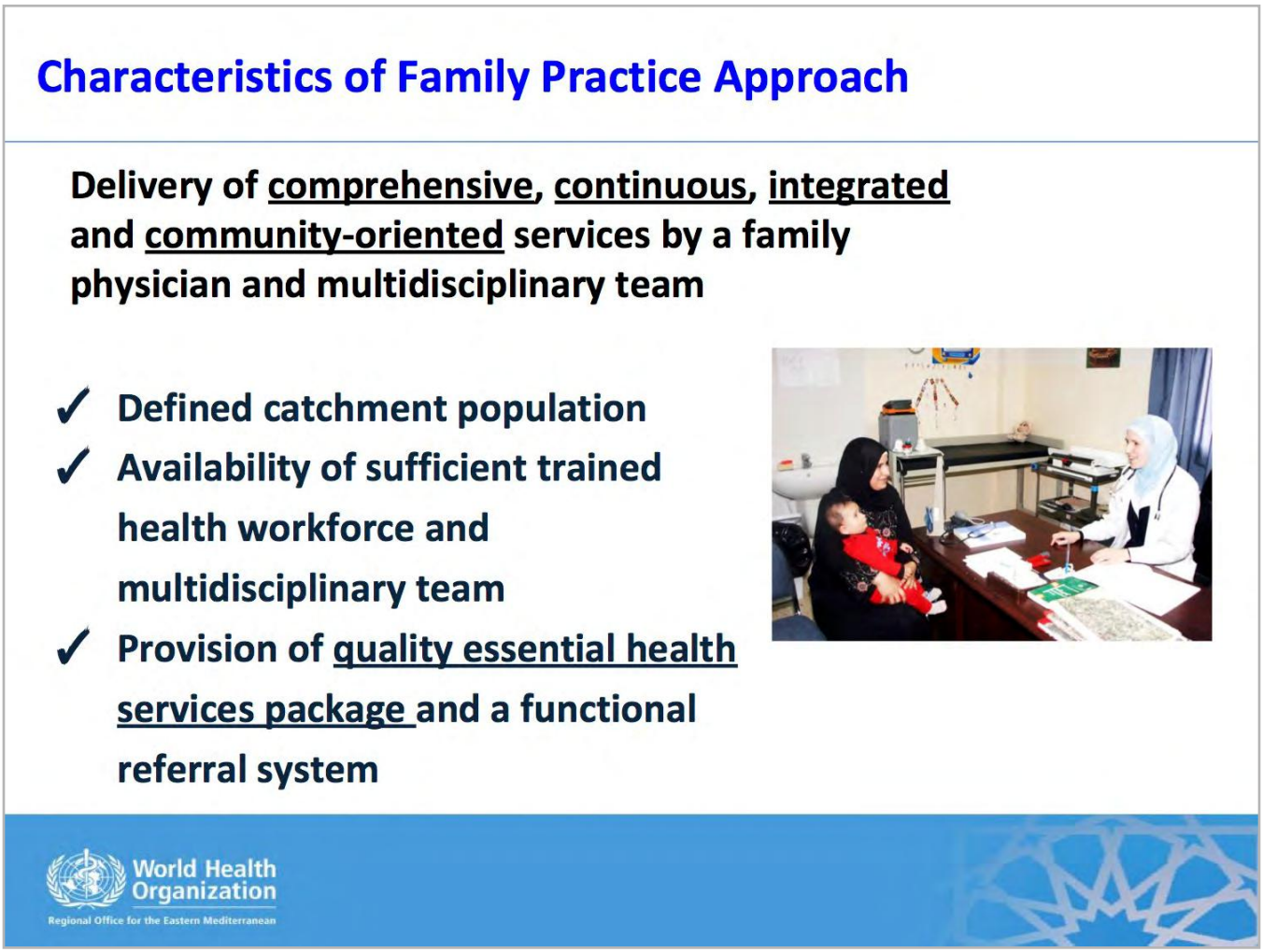
and service delivery around these interventions. We can then start discussing what is required in terms of health work force, health financing and service delivery arrangements to be able to deliver that package.



DCP3 COLLABORATIONS

(Min. 00:45:58)

Awad Mataria: I mentioned that we have been working with DCP3 and that we have been contributing to shaping the messages that are coming up in the different volumes. We conducted a series of economic evaluation studies in the region and we also organized several forums on the different volumes that were coming up, bringing in policy-makers, researchers and authors to discuss the findings in order to shape the outcome and to help informing policy-makers in a better way.

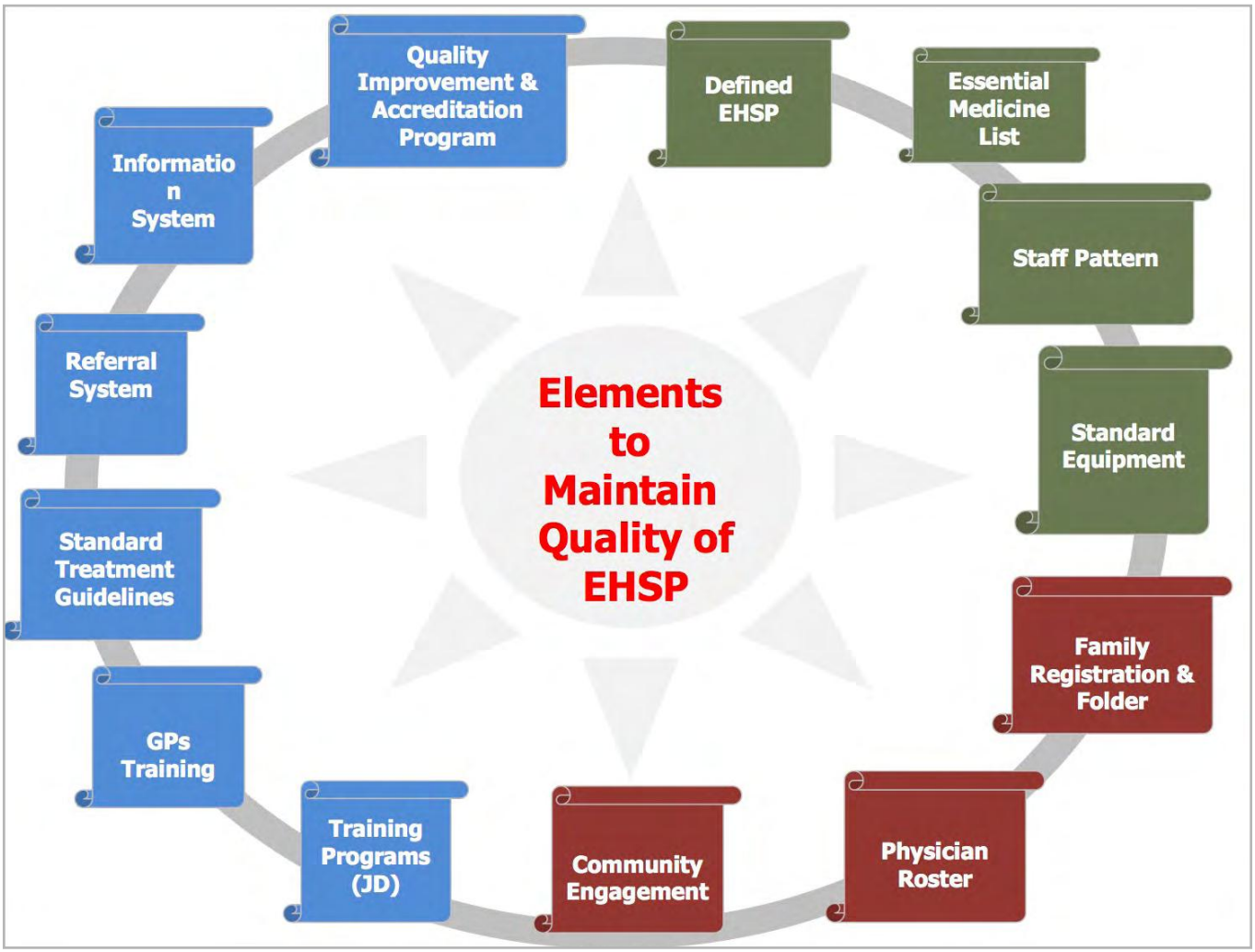


FAMILY PRACTICE APPROACH

(Min. 00:47:05)

Hassan Salah: At the WHO, in the Eastern Mediterranean Region, we are using the 'family practice approach' as an overarching strategy to maintain the quality of the essential health service package. You may know about the definition of the family practice. It is an integrated, community-oriented, comprehensive and continuous approach of the service delivery through the availability of the family physician. As you know we have a huge gap regarding family physicians in our region. We have to take into consideration that we need certain pre-requisites for the implementation of the family practice approach. The first one is a defined catchment population around the public primary health care facilities, in addition to the availability of sufficient trained

staff. We actually prefer to have a family physician and we try hard to encourage the generalized physician to be a family physician in our region. The last one is the quality of the essential health service package.

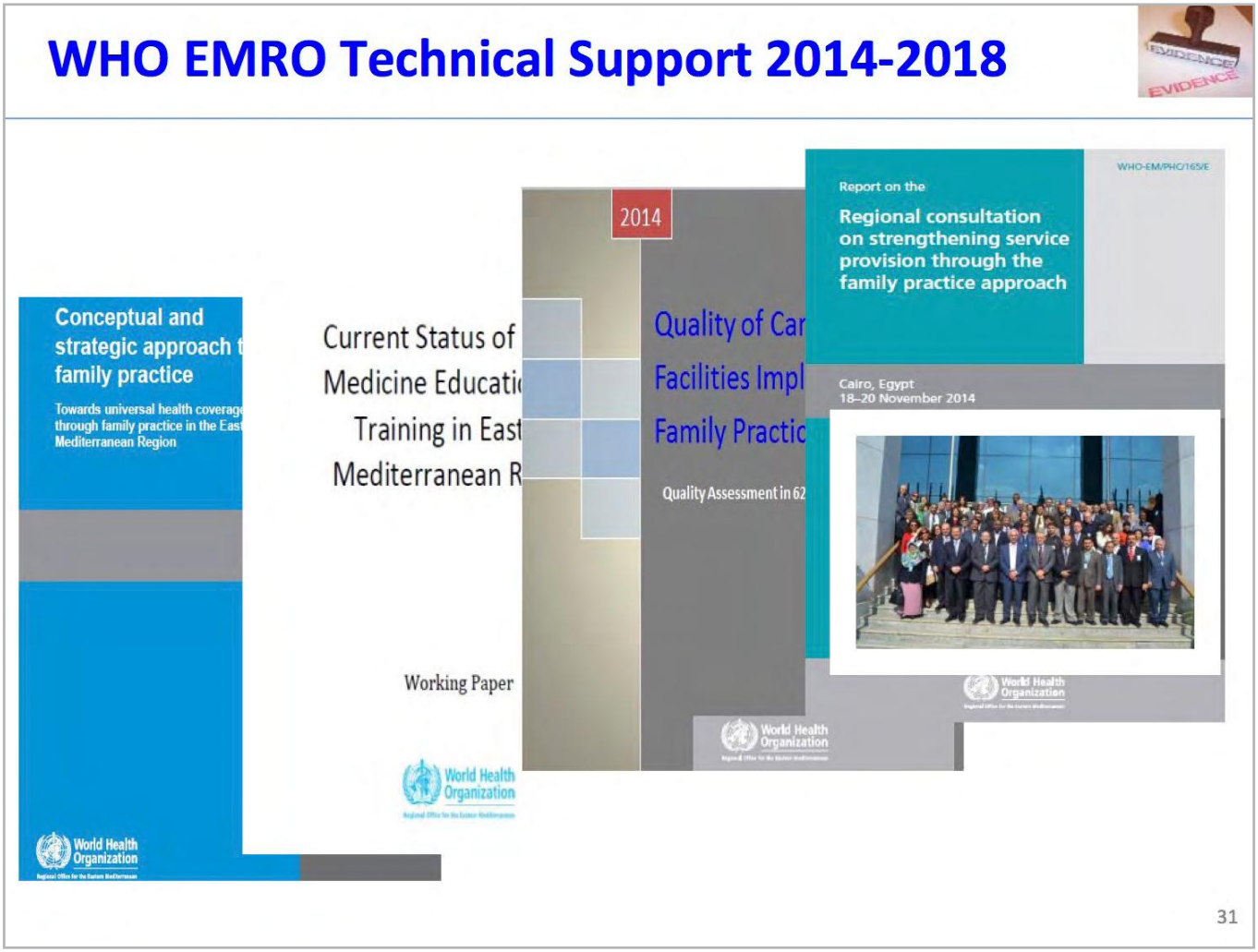


QUALITY OF EHSP

(Min. 00:48:33)

Hassan Salah: We identified thirteen elements and through these we try to maintain the quality of the essential health service package through the family practice approach. The first four elements of these are defined EHSP, availability of the essential medicine list, staff pattern and standard equipment. The next three elements are related to the catchment area around the primary health

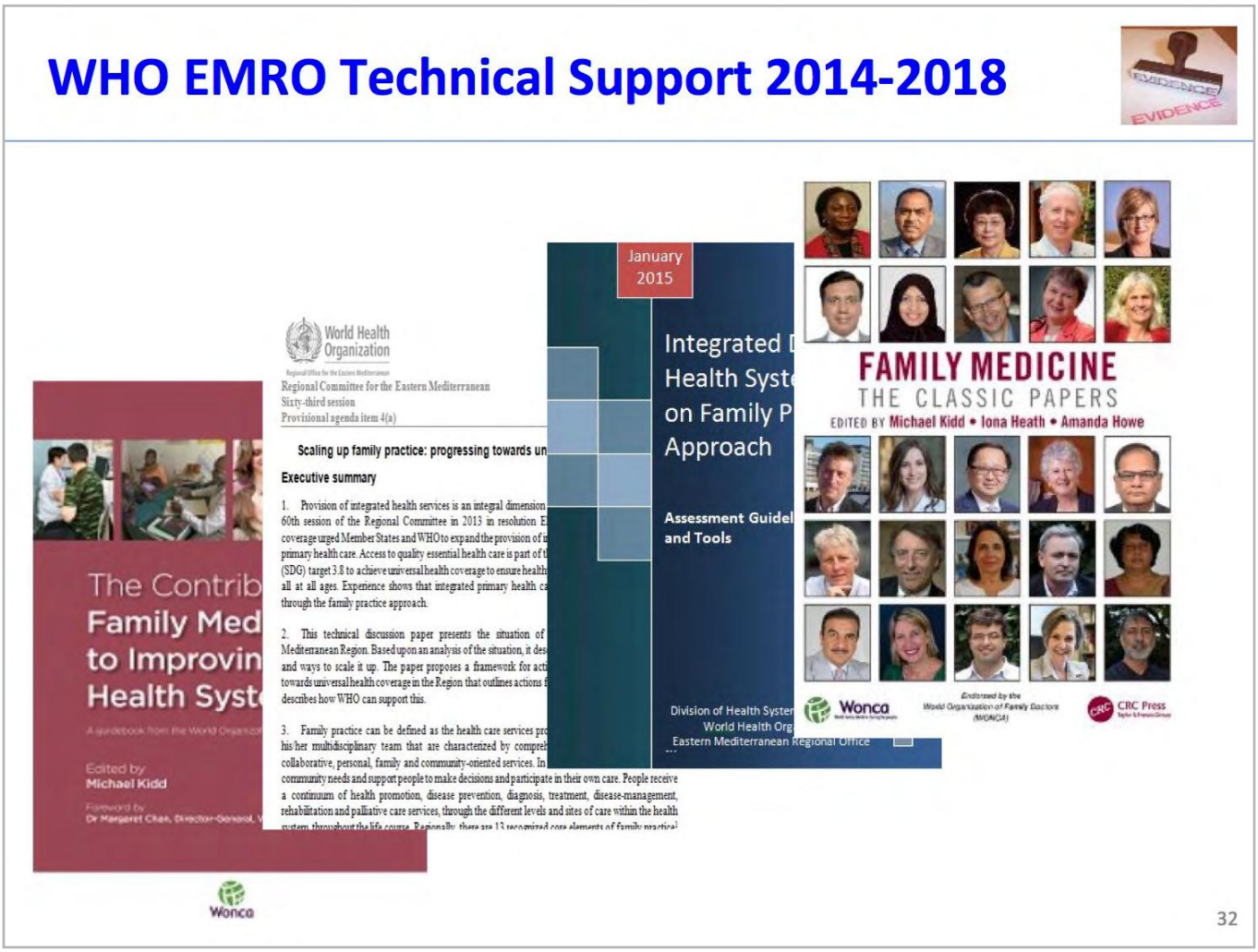
care facilities. These include the family registration and medical folders, the physician roaster and the community engagement. In addition, there are six elements related to the management inside the primary health care facilities. These include the training program, job description, the general practitioner's training, which is mainly and online training. It also includes standard treatment guidelines, referral system, information system and a quality improvement and accreditation program. These are the thirteen elements in which we are going to maintain the quality of the essential health service package through the family practice approach delivered in the primary public primary health care facilities.



WHO EMRO TECHNICAL SUPPORT 2014-2018

(Min. 00:49:47)

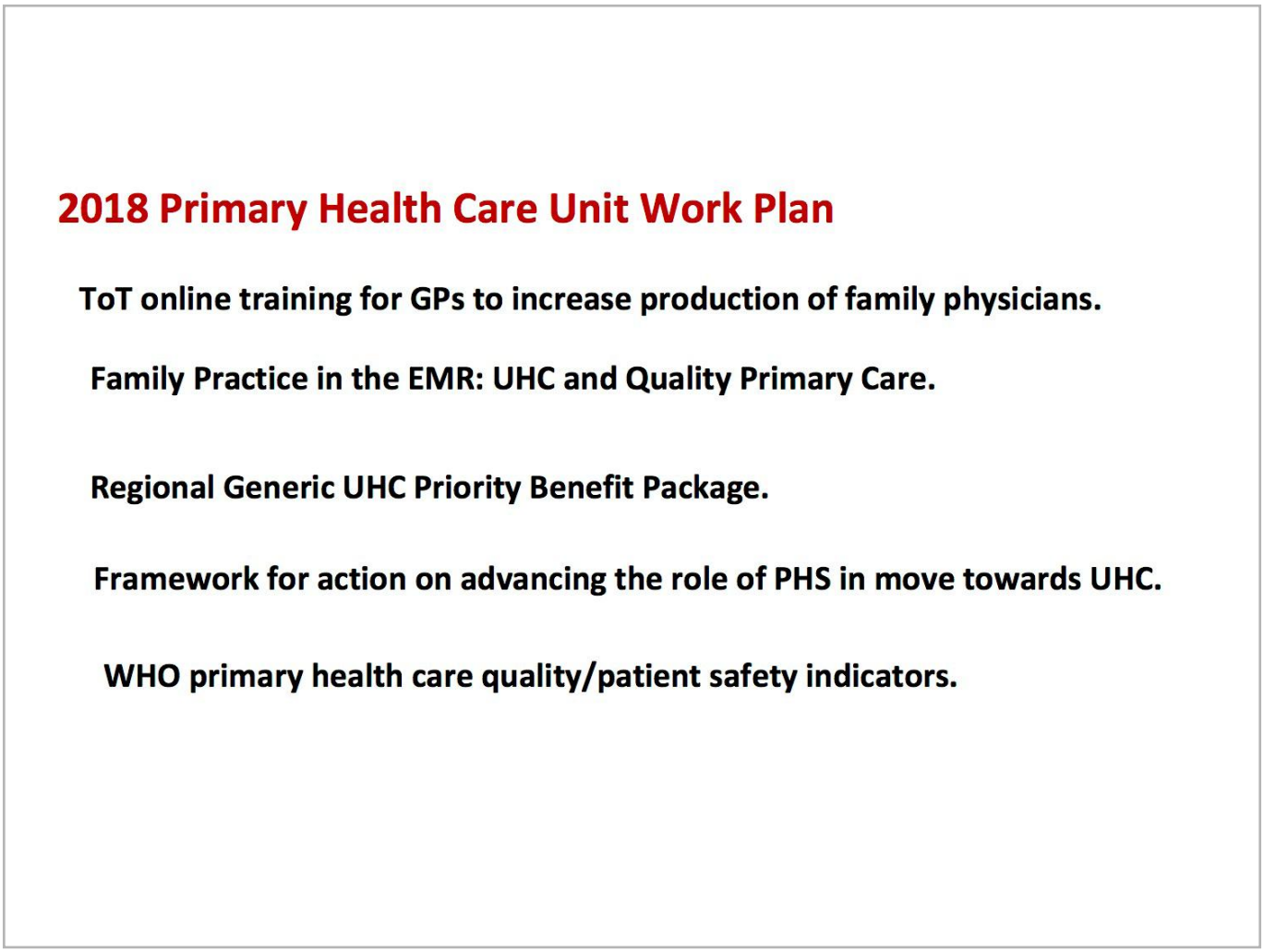
Hassan Salah: In order to raise awareness among the policy makers regarding the family practice approach and to have an evidence-based analysis, we conducted several assessments, for primary care, the thirteen elements of the family practice and the many workshops.



WHO EMRO TECHNICAL SUPPORT 2014-2018

(Min. 00:50:00)

Hassan Salah: We also contributed to some of the regional and global publications to raise awareness regarding the family practice among the policy makers in our region.



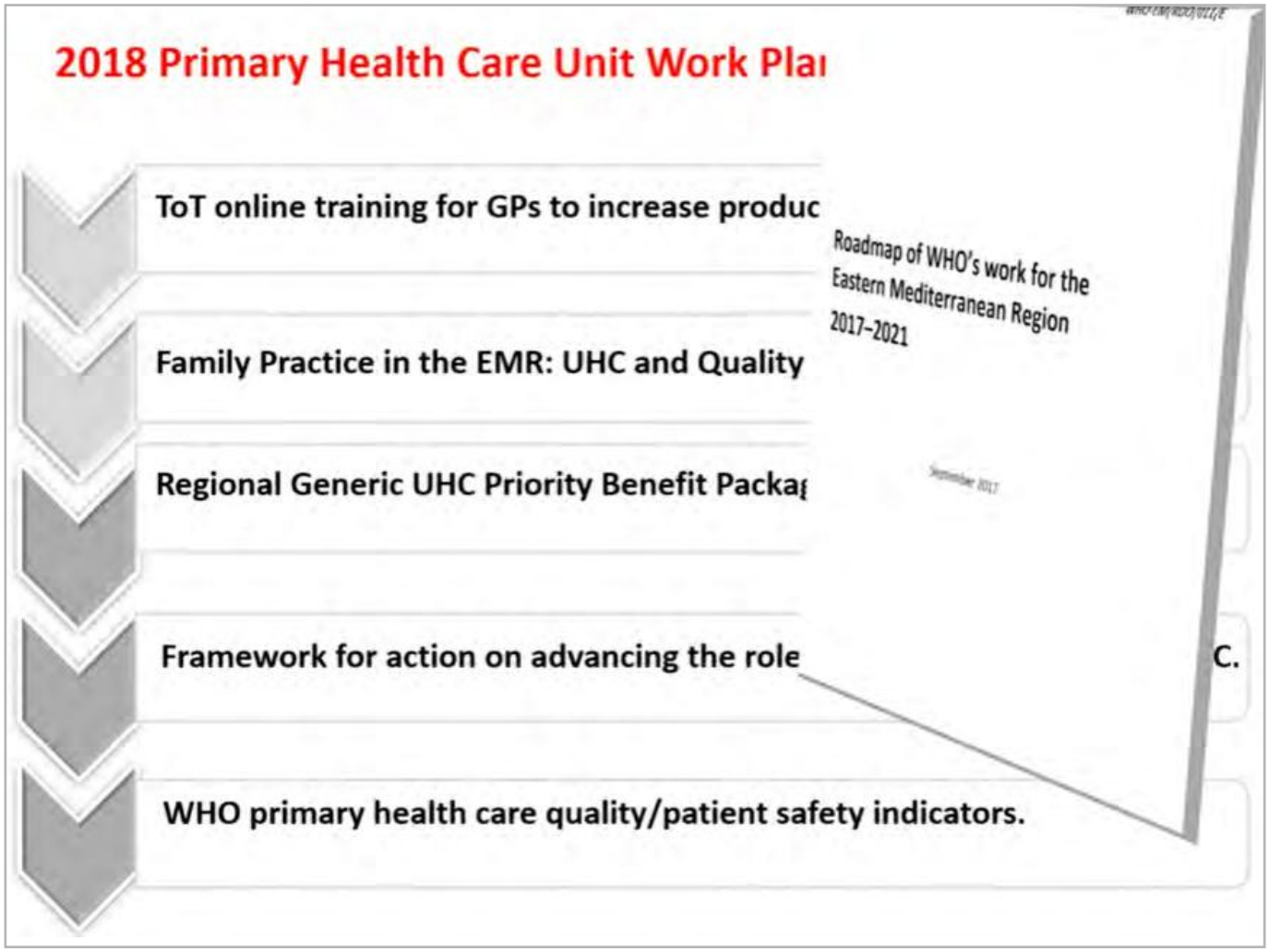
2018 PRIMARY HEALTH CARE UNIT WORK PLAN

(Min. 00:50:14)

Hassan Salah: To conclude, according to our work in 2018 for the primary health care unit at WHO we are working on five topics. The first one is that we continue working on the TOT for the online training of the general practitioners to increase production of the family physicians. As I mentioned before, we are facing a huge gap regarding the availability of family physicians. On average, we have around two thousand new family physicians every year. Taking into consideration, as I mentioned, that our region includes 0.6 billion people, there is a huge gap. That is why we are encouraging the generalized physicians to join this six months training as an introduction to the family physician. This is one of the resolutions

for our regional committee. This is the Ministers of Health annual meeting. We will continue working on this until 2020.

Secondly, for the first time we are going to publish a book on the family practice in the Eastern Mediterranean Region, with the title “Family Practice in the Eastern Mediterranean Region: Universal Health Coverage and Quality Primary Care”. This is exciting. We are going to launch this book in October in Astana and at the annual meeting of the Ministers of Health for our region. The book is actually a joint effort of WHO and the WONCA The World Organization of Family Doctors. The book is actually very important for us. It has thirty-four chapters. Twenty-two are country-oriented chapters and some of them are regional chapters, for example about the situation of family medicine in our region, the health workforce of the primary care, the impact of the emergency situation on the primary health care etc.



2018 PRIMARY HEALTH CARE UNIT WORK PLAN

(Min. 00:52:18)

Hassan Salah: The third topic, as we discussed it, is the development of a regional generic UHC priority benefit package, as Awad Mataria already explained.

Fourthly, we are working very hard focusing on the private health sector. As I mentioned before the private health sector is delivering most of the services, 70% of the services on average in many countries in the region. This is why it is very important to have a framework of action on advancing the role of private health sector to move toward UHC. In addition, we will have a technical paper and we will submit it to the annual meeting of the Ministers of Health, which will take place in October of this year.

Talking about quality and patient safety, as I mentioned we have serious challenges in this area. WHO has already developed 34 indicators for our region regarding quality and patient safety. We have already started implementing them in a number of countries at the primary care level. Actually, this quality and patient safety indicators became part of the roadmap of WHO work for the Eastern Mediterranean Region from 2017 to 2021.

QUESTIONS AND ANSWERS

(Min. 00:54:35)

Question:

How many countries are using health benefit packages in the region? Which are the most developed ones? Is there any country that is using a single benefit package for the whole population?

Answer Hassan Salah:

All of the countries have an essential health service package, without exception, in terms of availability as a document. Even in the low-income countries, for example Yemen, Djibouti and Somalia, they have very well-developed documents about the essential health service packages. But the question is about the implementation of the content of these documents. This is a serious issue.

(Min. 00:54:40)

Question:

In practical terms what does it mean to design a feasible health benefit package for a challenging environment, for example for countries that are in a state of emergency, like Yemen or Libya?

Answer Hassan Salah:

The major challenge in this context is the availability of the health work force, in addition to the availability of essential medicines. There is no referral there. The staff does not have any kind of training. This is a serious challenge. And the other issue we should be talking about is the availability of the infrastructure. 45% of the primary health care facilities in Yemen are not functioning because there is an absence of the health work force; there is no medicines and no equipment. In Libya, the situation is similar. Most of the facilitates in (...), which is one of the biggest cities, are not functioning.

Answer Awad Mataria:

If I may add to what Hassan has mentioned, if we look at situations like in Somalia or in Iraq, difficult places in the region, surprisingly enough countries have been progressing more towards defining the benefits packages because this has been mostly because these have been donor-driven activities. So where donors are coming in, they like to see what are the things that they can pay for, and what the package is that they can contract to NGOs or even to the public sector. There have been some attempts to produce these packages but often times because of a lack of proper involvement or dialogue around these packages, they remain as a document on the shelf without effective implementation. An example of a country in acute conflict is the case of Afghanistan where they managed to develop an essential benefits package and an essential hospital service package and they have been very successful by outsourcing it by contracting it out to the non-governmental sector. This has helped really very much in responding to the needs of the population and in delivering what is needed under such difficult circumstances.

(Min. 00:58:02)

Question:

Do you consider that there are pre-conditions to the design and implementation of the health benefit plan in a country or can they be potentially implemented in any country? If yes, which are those pre-conditions?

Answer Hassan Salah:

The pre-conditions depend on the content of the package. For example, if we see that the package includes some non-communicable diseases we actually need the staff to know how to deal with these non-communicable diseases. This is one thing. We also need medicines. If it is a hospital we need training for the staff not only for the physicians but also for the nurses. We need to develop the quality indicators etc. If we are talking about the pre-requisites for the implementation of the package it depends mainly on the content of the package. To give you an example, the situation in many countries here is that they do have the packages but when you look for the training there is no kind of training. What about the situation regarding essential medicines? Most of the times there is no medicine at the primary health care facilities. What about the equipment and the infrastructure? It is not there. That is why there is very limited quality of the delivery of the package in many countries.

(Min. 00:59:40)

Question from Andrea Ulrich:

Continuing on the previous topic regarding the countries with the heaviest conflict areas, Yemen and Syria, do you see the Afghan model as being a good example to be applied to other countries? For example, defining the health benefit package and then outsourcing to an NGO or another third party? Do you see this as a sustainable model?

Answer Hassan Salah:

Yes, to be honest this is a wonderful model. To have a contract based on a clearly defined package and to contract out to NGOs this is a wonderful model. I would love it to be implemented in other countries in our region. But we have serious challenges. It is kind of traditional that all the countries say that health and education are the priority and that they have to take the lead. Fine, but in the end the service deteriorates. Why? Because the countries are responsible for delivering the services through the public sector and they cannot fund it.

What happened in Afghanistan is that first they decided about the content of this package and then they went on to contracting with the NOGs. One of the issues is that they have a very good monitoring system regarding the quality of the delivery of the services. That is why I consider it a very good model.

Answer Awad Mataria:

I agree that we now compare Yemen and Syria as being countries in acute conflict. It has been different because the situation in Yemen is different than the situation in Syria. In Yemen, there is a lack of infrastructure.

The infrastructure for delivering services is not there, which was not the case in Syria. Of course, now with the current ongoing war things have deteriorated. I see that the example of Afghanistan of contracting and outsourcing is replicable and is something that could be relevant for a situation like in Yemen. But maybe in Syria the delivery of the public sector might also be considered. In Afghanistan, they have 34 provinces and they have been outsourcing in 31 of them and in three provinces it is the Ministry of Public Health that continues to have the lead on service delivery. And that is very important for sustainability. If we come to think about the long-term capacity of the national health system, to take over

and to be responsible for delivering services, then wherever it is possible it is good that we consider the public health infrastructure in the delivery of services. However, in such conditions, of course, Afghanistan chose this pathway and maybe it could be relevant for other countries in conflict to do the same.

(Min. 01:03:09)

Question:

Is there any evaluation in the region that shows the impact of the health benefit package in the reduction of out-of-pocket payments? Have benefit packages managed to bring more money to the health system?

Answer Awad Mataria:

The idea of the benefit package for us now is coming from the fact of the entitlement of people to have access to their needed health care services. So it is more important for us than the issue of raising more money. It is about defining what are the rights of people and making sure that people have access to these rights through a defined, explicit benefit package. Of course, once the package is there then one can look at the financial arrangement to raise resources to be able to deliver that package. It can be also seen by Ministers of Health as a tool to advocate for more money for health vis- a-vis the Ministry of Finance. But the essence of it is the entitlement, is to make it clear that this is a right for people to have access to at least these benefits. It is indeed in line with the approach that has been presented in the Lancet commission on investing in health, the recent one of December 2017, and the idea of progress of universalism. That even if you define a limited package you make sure that there is entitlement for everyone. Then, after that, you can start working on deepening that package and raising more resources to be able to be more generous in that regard.

Answer Hassan Salah:

As I mentioned in the beginning all countries in our region already have a package. So what is new in all of this exercise? We actually went to approach the countries and we encouraged them to review the current packages. Because the current packages are implicit, they are not implementable by any means because it is just a document and not more than that. We want the countries to review the current packages and interventions based on their technical

capacity, the human resources and their financial resources. All these things have to be considered and the countries have to start at least with a priority package and then they can add and work on it to see whatever the package could look like in the future. But they have to start with something that can be delivered in a decent way ensuring quality.

CRITERIA

Regional Network on Explicit Priority Setting and Health Benefits Plans

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