WEBINAR TRANSCRIPTION:

WHAT TO BUY FOR UHC? LEARNING FROM HEALTH BENEFITS POLICY AND PLANNING IN AFRICA AND ASIA

Presentation by Amanda Folsom and Nathan Blanchet, April 2015

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WHAT TO BUY FOR UHC? LEARNING FROM HEALTH BENEFITS POLICY AND PLANNING IN AFRICA AND ASIA

April 29, 2015

Webinar by **Amanda Folsom** and **Nathan Blanchet. Amanda Folsom** is currently Program Director at the Results for Development Instute (R4D), **Nathan Blanchet** is currently Program Director at the Results for Development Institute (R4D).

Drawing on experiences from the Joint Learning Network for Universal Health Coverage (JLN) and other recent work with countries in the midst of health systems reform, especially Ghana, this webinar will highlight how leaders and managers are deciding what health services and populations to cover, the role of evidence in the process, and what we can learn from these experiences to improve health benefits planning globally.

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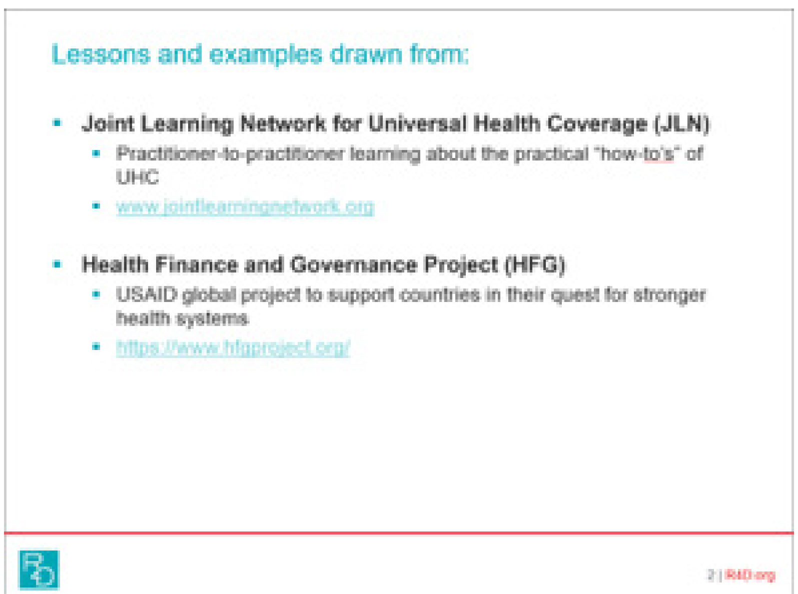
INTRODUCTION

(Min 20:57)

NATHAN BLANCHET

Health benefit policy has become a very widely discussed and debated challenge among the various debates on universal health coverage (UHC). We are seeing increasing demand for dialogue on this, and also demand for assistance from countries trying to figure out how to either create new benefits policies for new national health insurance programs, other financing reforms, or to revise existing benefits policies. I think this is really a global concern right now.



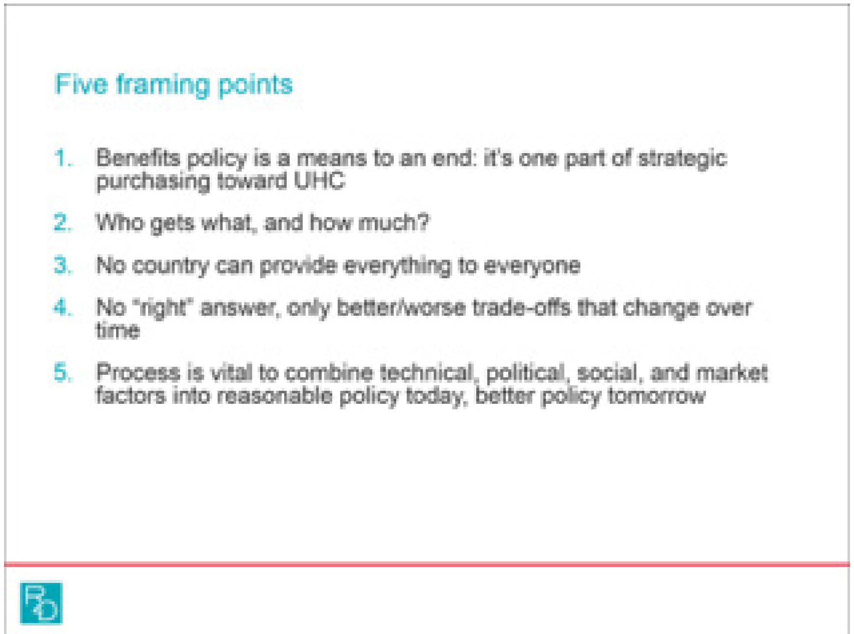
LESSONS AND EXAMPLES

(Min 21:58)

NATHAN BLANCHET

I will mostly draw from lessons and examples that Amanda and I have from two sources. One is the Joint Learning Network (JLN) for Universal Health Coverage (JLN). This network was launched in 2010 by nine founding member countries in Africa and Asia. Just this year, it is very exciting to announce, the addition of thirteen new associate member countries that come from around the world, including Colombia and Mexico in Latin America. JLN is a network of policy makers that are trying to share lessons, and create joint products that help with the more practical side, the operational side, of running programs that are dedicated to universal health coverage.

Secondly, our organization R4D is heavily involved in USAID's global project called 'Health Finance and Governance Project' (HFG). It works with approximately eighteen countries in trying to strengthen health systems, heavily focused on health financing reforms. Most of the countries are in Africa but there are also a few in Asia, Eastern Europe and some work is done in Haiti, in the Latin American region.



FIVE FRAMING POINTS

(Min 23:27)

NATHAN BLANCHET

Before we get into some specific examples and observations, I will point out some framing points that describe how we are thinking about health benefits policy. Those may be helpful to set some definitions and give our perspective. You will see themes of these points throughout the presentation.

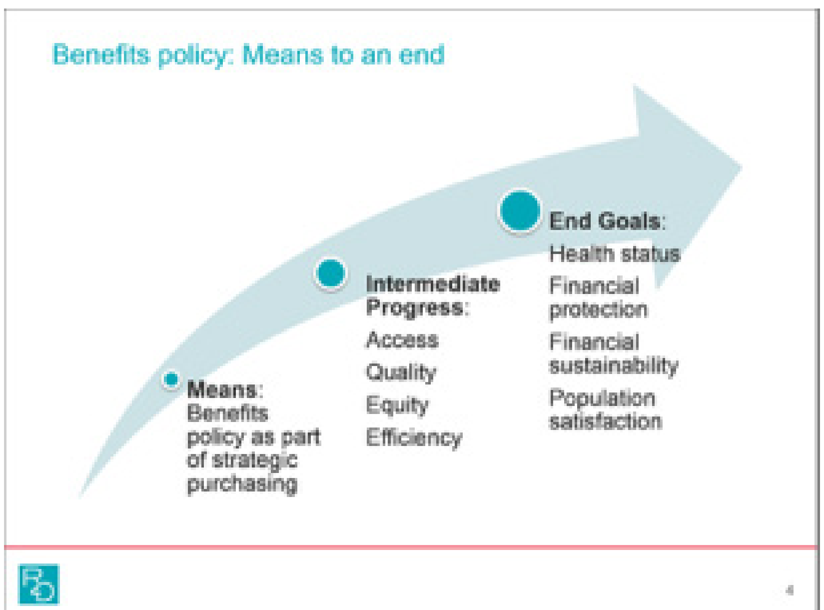
First of all, what is health benefit policy? It is about who gets what, and how much? The most obvious part of who gets what is what health services, particularly populations will have access to, how much of these services they can access, and of course, how much financial coverage they have for those. It is also important to remember that there is other dimension of these 'who-gets-what-questions'. Benefits policies determine what providers get, what they are expected to do, and how much risk they hold, as well as other stakeholders in the system. When you have a very basic question like this about resource allocation, that touches on many stakeholders, it of course means that benefits policy is an inherently political issue, as well as a highly technical one.

The second issue is that we don't view benefits policy in a vacuum or by itself. We view it as a means to an end, and also as one part of strategic purchasing. We see it as much more as what services are in a basket, or outside of a basket, and rather a part of a larger whole that is aiming towards particular goals.

Thirdly, no country can provide everything to everyone. There are resources constraints even in the richest countries. Every country across the income scale is dealing with how to prioritize health services and how to allocate those within resource constraints. This raises a lot of similar challenges everywhere.

Fourthly, there is no right answer. As much as there are sophisticated tools, for example for cost effectiveness, there is not one right benefit package. Rather there are better or worse tradeoffs that are constantly changing. That reality points to our final framing point.

We have come to believe that the process of benefit policies is really vital and more important than the particular benefit package that gets defined. It is really necessary to have a strong and transparent process in order to combine the technical, political, social and market factors that must be considered in shaping health benefits policy today, and to continuing to improve it in the future.

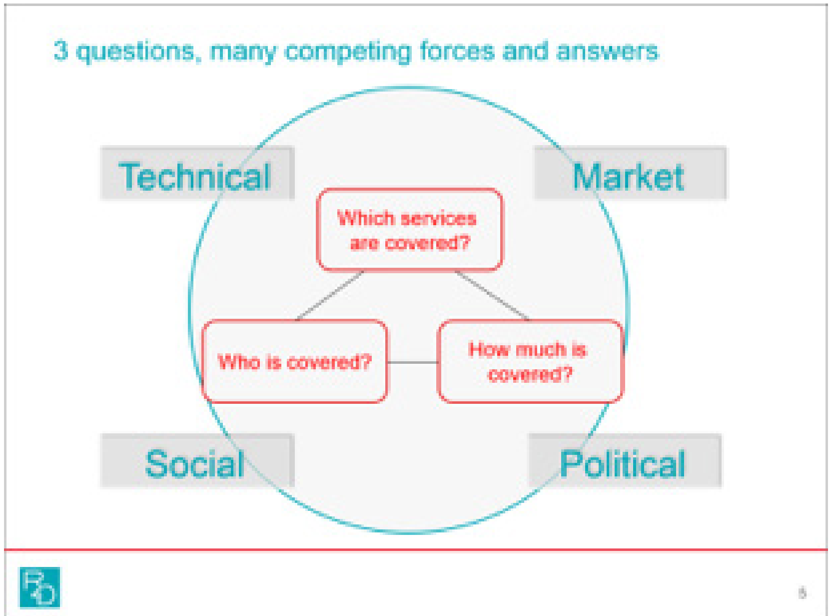


BENEFITS POLICY: MEANS TO AN END

(Min 27:09)

NATHAN BLANCHET

I will show just a couple of graphics to underline some of those points. This graphic borrows from several health system models, but I think it makes an important point. We are talking about health benefit policy and we are thinking about changing benefits policies for a reason. The reason is that we are trying to use the purchasing function of health financing to get certain things. In the near term, countries want to improve quality, access, equity, efficiency in their health system and they want to do so because they want to improve health status, financial protection, have a sustainable health financing system, and provide a health system that is satisfying to the public.



3 QUESTIONS, MANY COMPETING FORCES AND ANSWERS

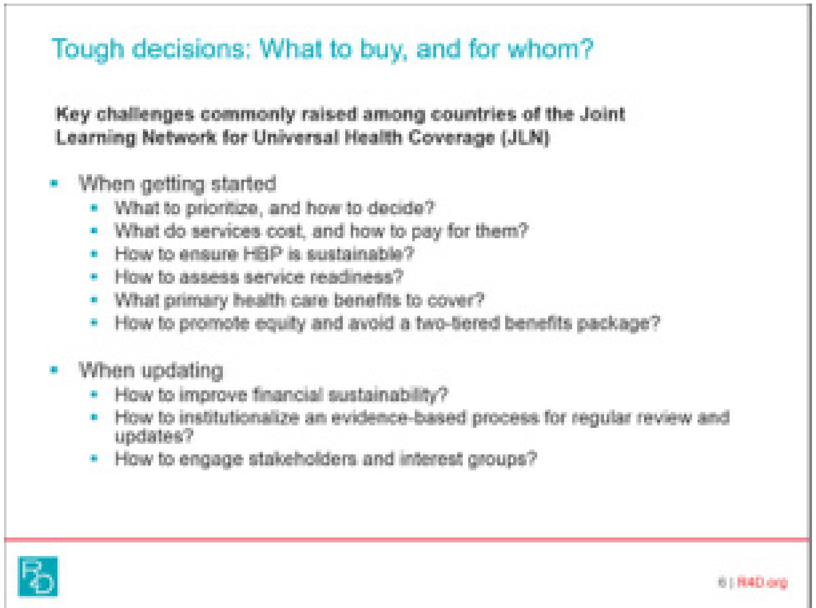
(Min 28:08)

NATHAN BLANCHET

The next slide shows that we find that there are multiple forces affecting those decisions. One that tends to get the most attention among policy makers is the technical box. This includes the technology assessments, cost-effectiveness approaches, epidemiological models about the health needs; the kind of debates that are really dominated by the health technocrats. But there are other forces that can be equally important. The market characteristics in a country will determine costs and what is affordable, or not affordable. Given the questions that are at stake, and how it affects people, inevitably this is a highly political process. Social preferences must also be taken into account.

The classic textbook case is when the state of Oregon, in the U.S., tried to rationalize its Medicaid program. In their first attempt they took their technical box very seriously. The cost effectiveness analysis ended up rating tooth capping higher that appendectomies. This led to a social revolt and through a series of revisions they have come up with a way of incorporating social preferences better into their rationing of the medicate program.

With those framing points I will turn over to my colleague Amanda.



TOUGH DECISIONS: WHAT TO BUY AND FOR WHOM?

(Min 30:51)

AMANDA FOLSOM

I would like to frame a little more the challenge as we see them, especially from the work that we have been doing across a number of countries in Africa and in Asia with the Joint Learning Network (JLN). In the JLN we have a range of countries at different stages of development, and different levels of UHC progress. Some that are just developing their UHC strategies and some that have achieved or nearly achieved universal health coverage (such as Mexico and Colombia).

The theme of benefit policy and planning has emerged as a major challenge area we are exploring. We are looking at how we can integrate more practical problems around this issue within the JLN. I think there is a lot to learn from the Latin American experience and hopefully we can find a way in the JLN to integrate more of your reflections in the future.

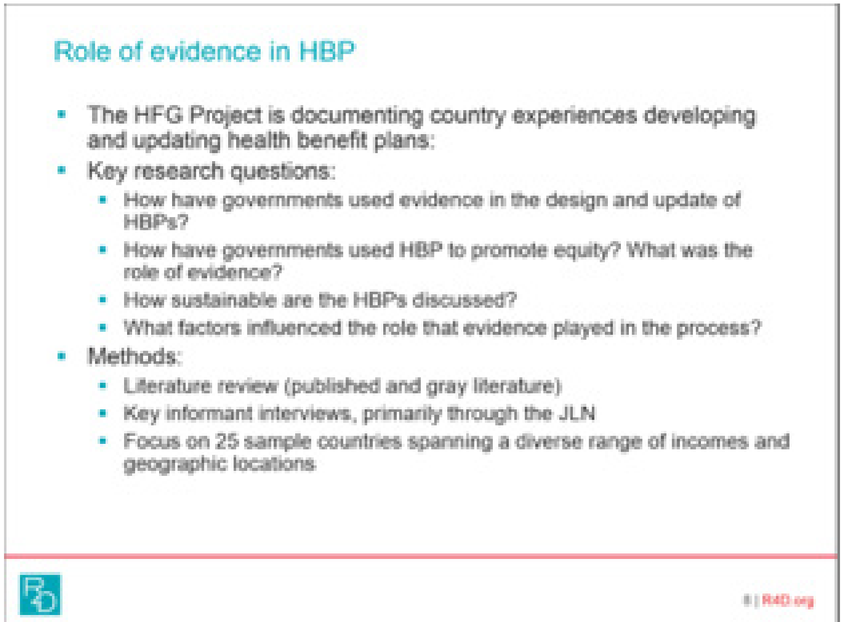
Nathan has already touched on some of the key questions that emerge. Yet, the JLN network works with countries that are just getting stated in asking question about what to prioritize, how to make those decisions, how to put together a transparent process to do so. Practical and technical questions about how much it costs and how to pay for them have a lot of work through the JLN, payment mechanisms for example and benefit policies comes up repeatedly in this discussions as a strategic purchasing tool. Sustainability and financing is certainly a major issue and another one that we are turning more attention to is on service readiness and how to assess the supply side in terms of formulating a benefits package. In the future we will be looking more closely at benefits designed for primary care. We have a whole initiative in the JLN focused on the questions of primary care benefits. We are also working with countries that are at the stage of updating their benefits packages and questions arise like how to add benefits or how to take them away potentially in the event that there is not enough cost effectiveness or certainly limits of resources.

PRIORITIZATION REQUIRES MAKING TRADEOFFS

(Min 33:38)

AMANDA FOLSOM

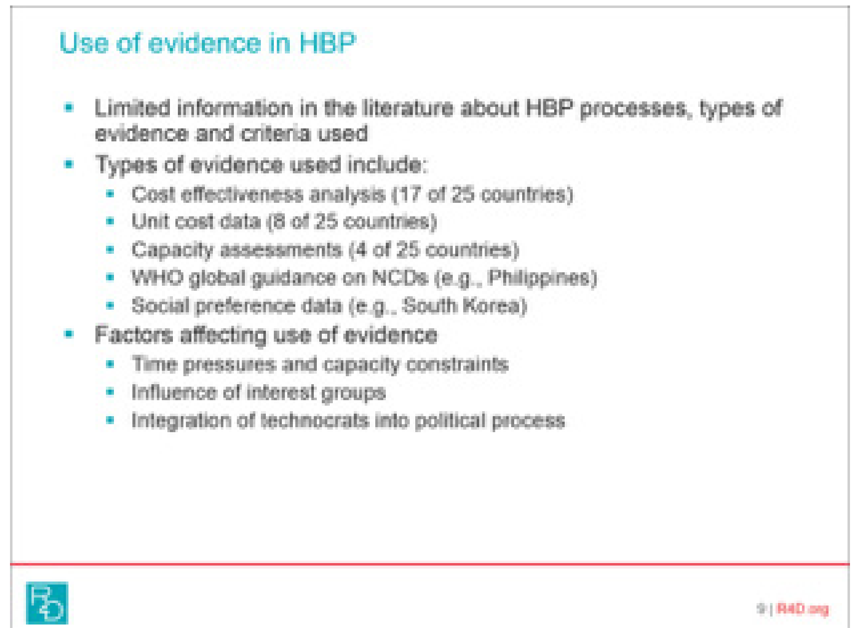
Prioritization of benefits certainly requires many tradeoffs and policy makers are daily weighting the questions of what to cover and whether to cover more people or provide more services, whether to focus on the political or on the longer term (short term vs. long term challenge) impeding interests from interest groups or focusing on core societal values. Technical questions around: do we rely more on cost-effectiveness or on other criteria and how do we balance those. Do we focus more on improve financial risk protection or focus more on health outcomes which relates to if policy makers and practitioners might focus more on coverage to inpatient services or outpatient and primary care. These are just a few examples of the type of chaos tradeoffs that comes up daily and that I am sure many of you are confronted with in your work. I think there is no single right answer globally, each country has to weigh the trade off to achieve the best outcome for its context.



ROLE OF EVIDENCE IN HBP

(Min 35:00)

I will focus now on some of the work that we have been involved in with the "The Health Finance and Governance Project" (HFG), that Nathan and I are both involved in. This project focuses on documenting experiences around the globe in developing and updating health benefits plans. Typically, the question is how governments are using evidence in the design and updating process and specific questions about equity and sustainability that have emerged as thematic areas in this work. This has been conducted through a literature review, a series of key informant interviews and we used a sampling methodology and arrived at a sample group of twenty-five countries, nine of which are part of the JLN, eight of them are part of the Latin American community as well, with some overlap of the JLN. I would like to share some of the preliminary findings that are emerging from this work.



USE OF EVIDENCE IN HBP

(Min 36:20)

AMANDA FOLSOM

What we have found, in doing the literature review in particular, that there really is limited information in the literature about the processes of benefits planning and the types of evidence and criteria that were used. There is not a lot of process documentation. We relied heavily on key informant interviews and qualitative research methods to round up this analysis. Some of the key types of evidence we are finding that are used include cost-effectiveness analysis that show up in the majority of the countries in the sample, as a primary type of evidence. Unit cost data shows up in about a third of the countries and then we have some examples of other types of evidence like supply side capacity assessment, global guidance from the WHO on NCDs, data on social preferences and population preferences.

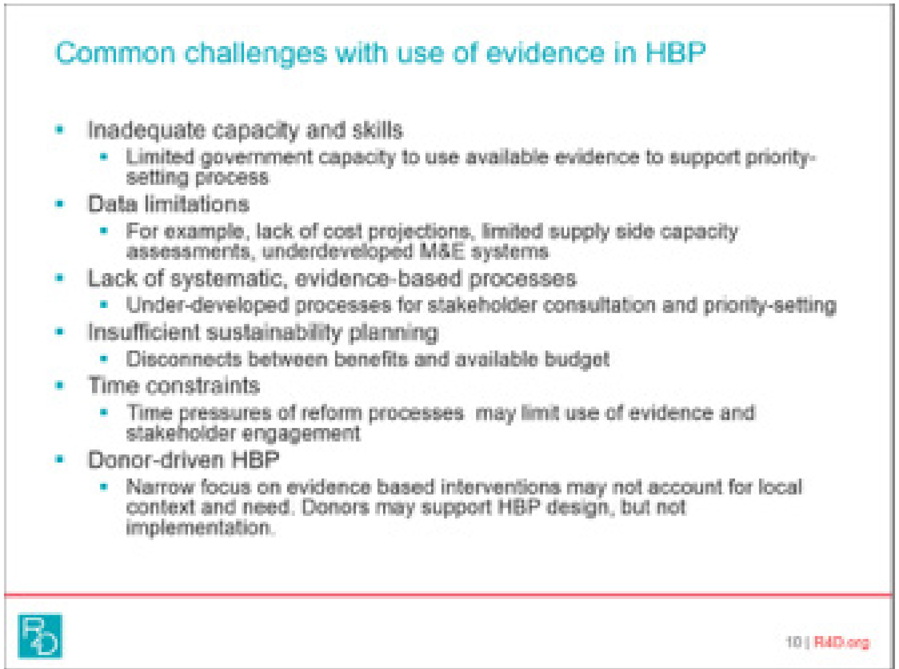
When we have spoken with key actors and policy makers in some of the countries that we have focused on in this analysis, they cite time pressure, especially in the reform process, and feel the capacity constraints as being some of the key factors that influence whether or not they can integrate, or not, a lot of evidence into their benefits planning processes. Certainly, the political influence and influence of interest groups contributes to that. Some countries have taken a highly technocratic approach, and others a highly political approach. The question about how these two might be integrated has a key role to play in the extent to which evidence is used in this process.

(Min 38:20)

Question from the audience:

How are different countries using social preference data?

I was just thinking about an example from South Korea. South Korea has formed a group of citizen panels and has randomly selected citizens from across the population to contribute their viewpoints and perspectives on key services and benefits, that are under consideration in the Korean national health insurance scheme. They have a very systematic process for citizen engagement that gets elevated and integrated in both the technical and the political processes. That is just one example of citizen engagement and integrating social preferences, and there are certainly others. This is something that we could roll out more, and share more examples on in our findings.



COMMON CHALLENGES WITH USE OF EVIDENCE IN HBP

(Min 39:45)

Government capacity and skills to collect and use the data for priority setting processes comes up as a major challenge. This is not surprising. Certainly there are limitations in both availability and quality of data, costing data, supply side capacity, and generally underdeveloped monitoring and evaluation systems to continuously monitor and adjust the benefits package along the way. Other key challenges are the lack of a systematic processes for confrontation with stakeholders and a disconnect between benefit planning and budgeting processes. There are time constraints and technocrats are often under an incredible pressure to try to create, design or update a benefit plan. This may not allow for a great deal of evidence, research and stakeholder engagement. That has also emerged as a key finding.

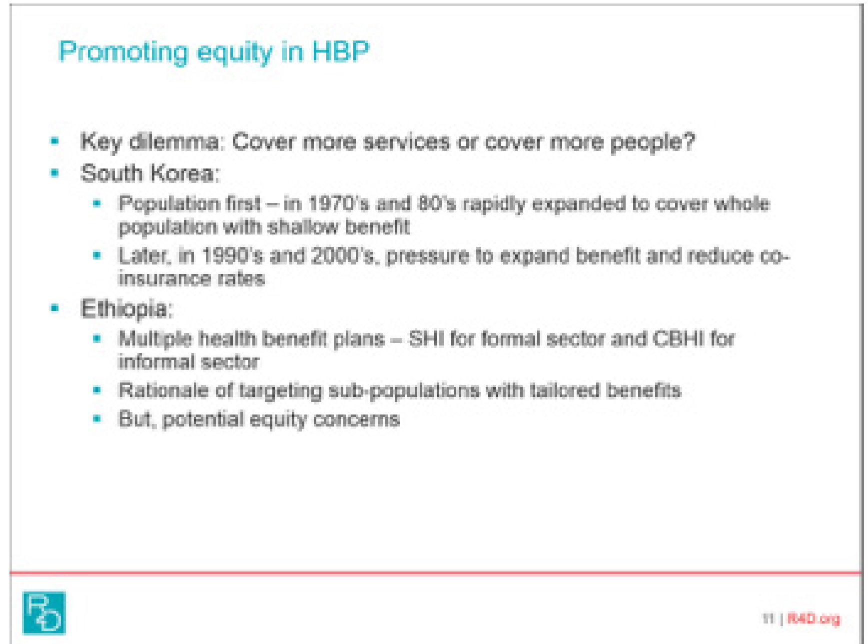
Another aspect that has been coming up, especially in the low income context, in our work is that donors have a very influential role in some countries, especially in Africa in terms of defining and putting pressure on the coverage of certain key interventions that are of interest that are cost effective and maybe not necessarily accounting for the local context, creating some different pressure and eventually maybe distracting or complicating the situation in terms of the process. Another point is that donors are tending to get very much involved in the design process, in terms of what is in the benefits basket, but pulling out or loosing attention when it comes to implementation.

(Min 42:15)

Question from the audience:

Regarding the use of evidence, how are the different types of evidence combined?

This varies from country to country. Each country has to decide how to weigh the different types of evidence, based on the available data, the time that is available and try to put together a coherent picture to make the best possible decision. I don't think there is a 'one-size-fits-all' formula for how to package and assemble the different types of data sources. Yet, what we are seeing is a variety of combinations. The communality that we see is some use of cost effectiveness analysis in most of the countries, and to a lesser extent, some use of costing and consumer preference data. The question for the future will be whether there could be more guidance given to countries on how to weigh the different forms of evidence.



PROMOTING EQUITY IN HBP

(Min 43:40)

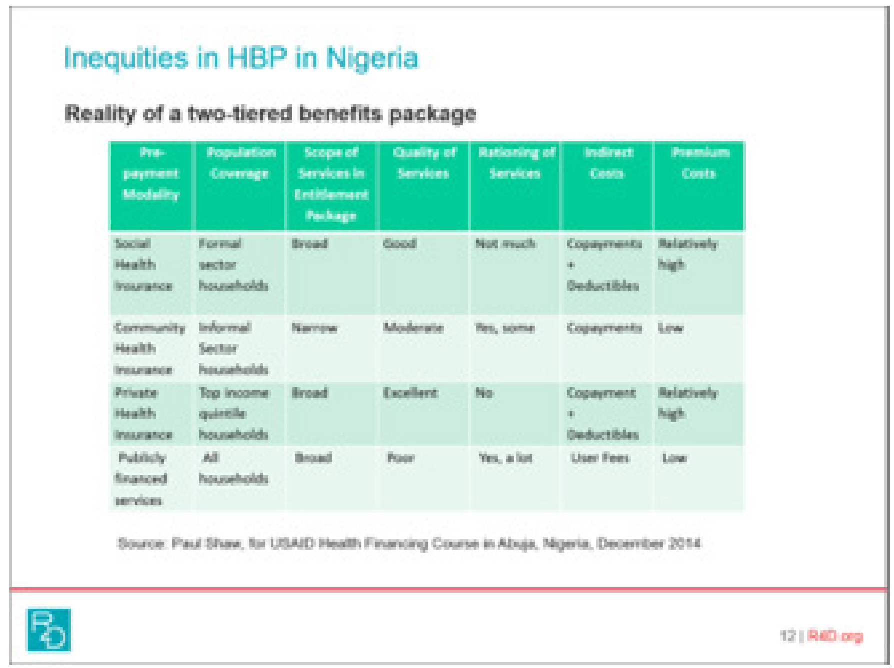
AMANDA FOLSOM

Another area of interest in the Health Financing and Governance Project on use of evidence, but also more broadly in our work at the JLN, is around equity and benefits packages. Certainly one of the key questions is related to the fundamental trade off regarding: Do we cover more services or do we cover more people? This implies a sentimental tradeoff.

Some contracting examples will illustrate this key challenge: For example, South Korea took, for the last 30 years, an approach of rolling out of coverage for the whole population and prioritize coverage of all, but with a very shallow narrow benefit. Then over time gradually it has expanded and deepened the benefit and reduced some of the coinsurance, the out of pocket cost, to the population.

What we see in some cases in Africa, by contrast, is a case where some countries are designing multiple schemes or benefit plans, they are tending to start with a special health insurance model for the formal sector with a relatively comprehensive benefits package and then secondarily designing a program or package for the informal sector, the poor and the non-poor. Many countries try to build off build off a community based health insurance, with the rationale that they can turn the benefit package to the different populations and their unique needs. Certainly this raises a number of equity concerns when you look at the benefits package.

I will mention two examples: Nigeria and Thailand. Nigeria is a case that illustrates that point. Nigeria has a special health insurance model that covers the formal sector population. Coverage is still quite small across the population and they are trying to scale up coverage through their community health insurance to cover the informal sector. In reality there is a two-tier benefit, a challenge that Nigeria faces and it is really grappling with as it tries to define its UHC strategy for the future. Meanwhile they have, in principle, public services available for all but certainly a lot of rationing happening in the government sector and overall poor quality. A key challenge for Nigeria will be how to move to a more equitable benefit policy in the future as it moves towards universal health coverage. I was just in a meeting in Nigeria a couple of months ago and this is a major issue among the policy makers both at the state and at the national level.


Inequities in HBP in Nigeria

Reality of a two-tiered benefits package

Pre-payment Modality	Population Coverage	Scope of Services in Entitlement Package	Quality of Services	Rationing of Services	Indirect Costs	Premium Costs
Social Health Insurance	Formal sector households	Broad	Good	Not much	Copayments + Deductibles	Relatively high
Community Health Insurance	Informal Sector households	Narrow	Moderate	Yes, some	Copayments	Low
Private Health Insurance	Top income quintile households	Broad	Excellent	No	Copayment + Deductibles	Relatively high
Publicly financed services	All households	Broad	Poor	Yes, a lot	User Fees	Low

Source: Paul Shaw, for USAID Health Financing Course in Abuja, Nigeria, December 2014

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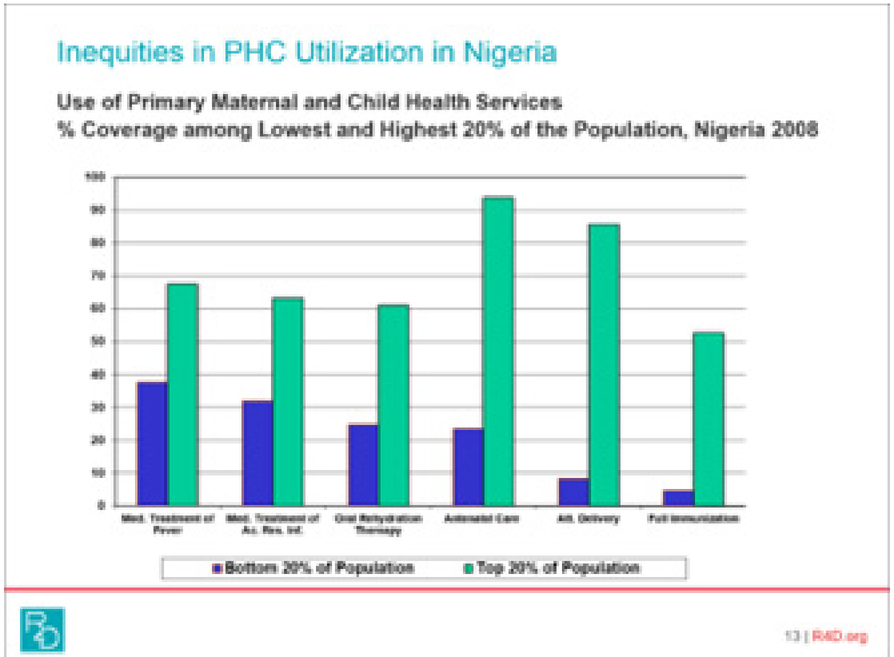
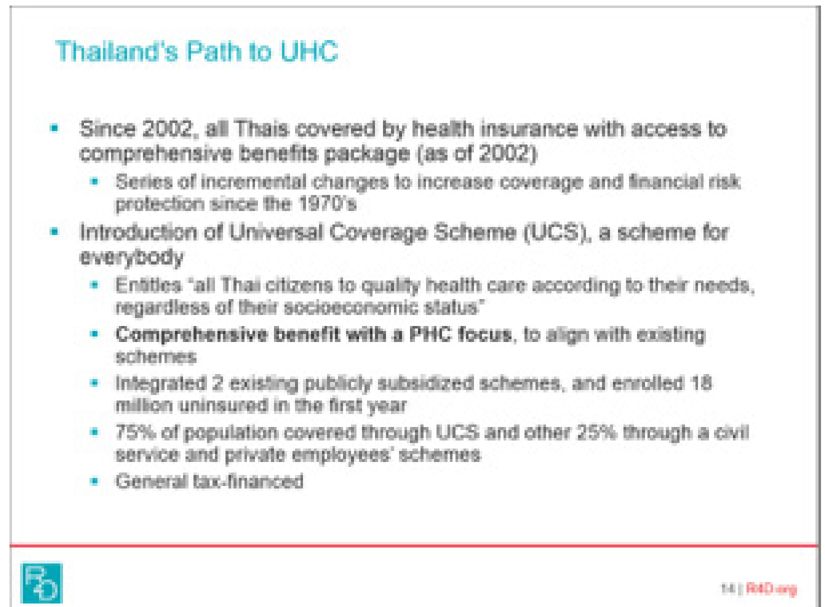


INEQUITIES IN HBP IN NIGERIA

(Min 46:55)

AMANDA FOLSOM

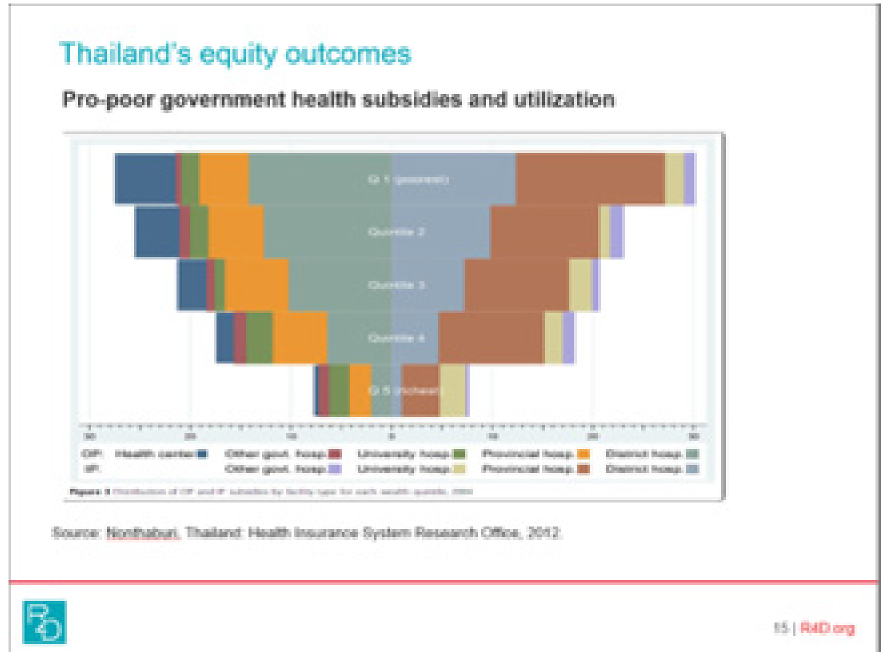
As you can see the outcomes for equity in Nigeria are quite poor at the baseline. Nigeria shows some of the worst disparity in terms of utilization of services. This graph illustrates some of the inequities of primary care utilization of some key maternal and child health services. You can see that looking at the distribution of gross economic quintiles, the population of highest income in some cases is receiving primary maternal and child health services at a rate three to ten times higher than in the lowest income quintile. Nigeria certainly faces a major equity challenge and looking at how to design an equitable benefits policy to try to address that challenge.



THAILAND'S PATH TO UHC

(Min 47:48)

Thailand by contrast, a country that has achieved UHC, and rolled out a major comprehensive primary health care service benefit for all in the early 2000 with services that are free at the POS, had integrated schemes so that there was a uniform benefit policy across the whole population. They did use some scheme integration however Thailand still operates two schemes: the universal coverage scheme that covers 75 percent of the population and a civil service scheme that covers 25 percent of the population. But the benefits packages are approximately the same.



THAILAND'S EQUITY OUTCOME

(Min 48:31)

AMANDA FOLSOM

I would like to illustrate the equity outcomes in Thailand's case. Thailand is often held up as a great example for pro-poor universal health coverage with a much more equitable coverage. I you look at this example from benefits incidence analysis in Thailand you see that most about how resources have been distributed across inpatient and outpatient benefits, or who has received what benefit, across economic quintiles, the poorest have actually stirred relatively well compared to the richest quintile in terms of public subsidization of services. That has driven some of the equity outcomes that have been so positive in Thailand's experience.

Ghana Health Profile

Population	25,904,598
GNI per capita (PPP / Current Ex), $US	$3,900 / $1,770
Life expectancy at birth, total (years)	61
Under-5 Mortality (per 1,000 live births)	78
Maternal Mortality Ratio (per 100,000 live births)	380
Prevalence of HIV, % ages 15-49	1.3%
Incidence of TB, per 100,000	66
Total Health Expenditure per capita (PPP 2011), US$	$214
Total Health Expenditure, % GDP	5.4%
Births attended by skilled health personnel, % of all births	68 (2011)
Physicians per 1,000 population	0.1 (2010)

Map Source: http://www.lib.utexas.edu/maps/africa/ghana_admin_2007.jpg

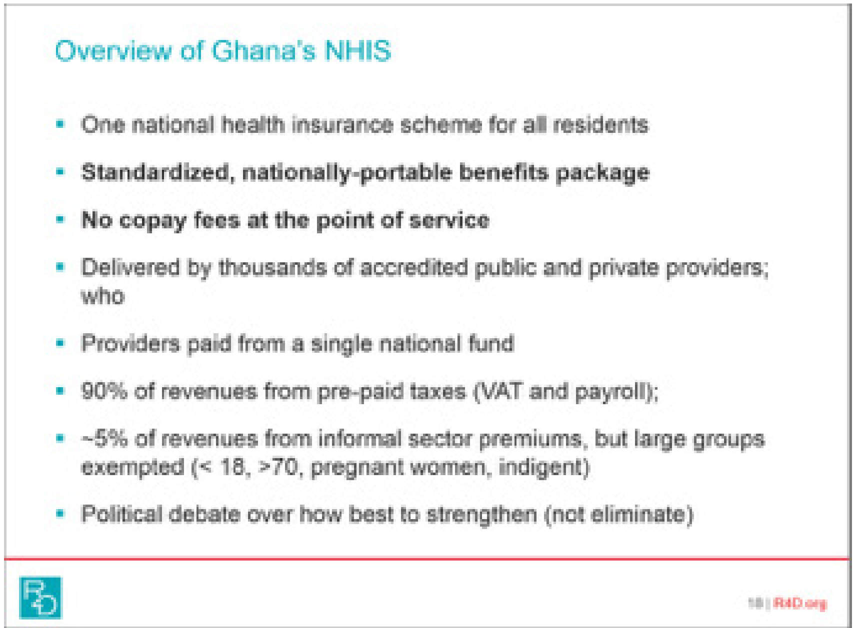
Sources: World Bank's World Development Indicators and WHO's Global Health Observatory (2013, unless otherwise noted)

GHANA HEALTH PROFILE

(Min 51:30)

NATHAN BLANCHET

I will spotlight Ghana now. Ghana is well known for its national health insurance scheme. It is a lower-middle income country with a lot of success stories in both health and democracy but it is still facing major challenges. Ghana has a high under five mortality rate of 78 per 100.000 births, extremely limited resources in terms of human resources for health with a 'physician per 1.000 population rate' of just 0.1, which is ten times lower than typical averages in Latin America.



OVERVIEW OF GHANA'S NHIS

(Min 52:24)

NATHAN BLANCHET

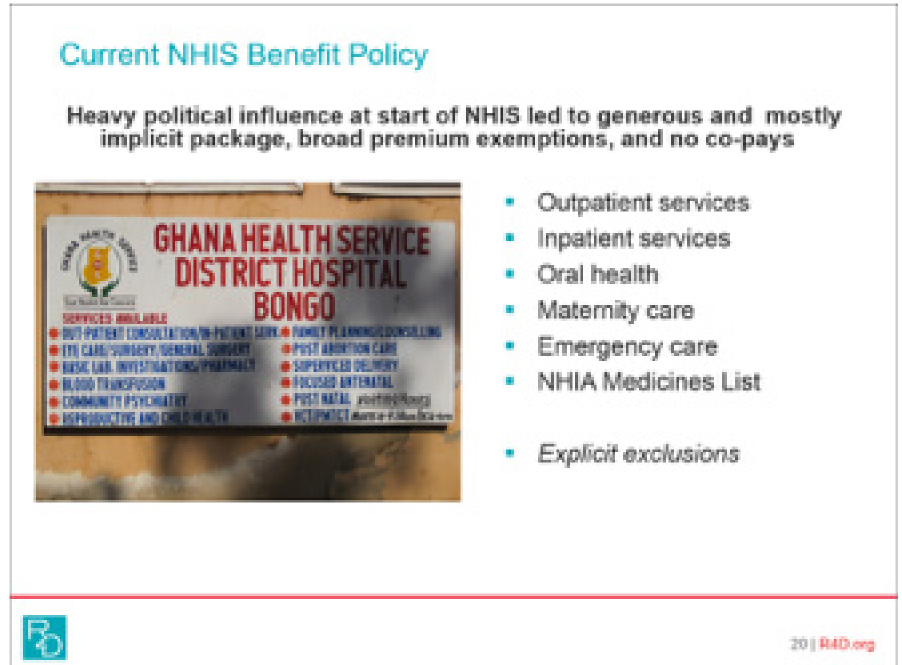
Ghana is best known in health policy circles for its national health insurance scheme. It was started in 2003 and I have tried to condense the most vital point about it. It is one national health insurance scheme for all residents, formal sector and informal sector. It has one national portable benefits package. There are still at this point no official co-payments at the point of service. Delivery is by public and private providers. They are credited by the national health insurance authority. The revenues come mostly from pre-paid taxes, about 70 percent from a value-added tax, some more contributions from formal sector payrolls, and only about 5 percent from informal sector premiums, for which there are also large exemptions granted e.g. to children, the elderly, pregnant women.

GHANA'S CONTINUALLY EVOLVING BENEFITS POLICY

(Min 53:30)

NATHAN BLANCHET

I always notice, that compared to the U.S. context, the political debate on NHIS is really about how to strengthen it, rather than eliminating it. When it comes to benefits policy, I really view Ghana's benefits policy as constantly evolving since its independence in 1957. At independence they started with a policy of free care at public facilities but that was very limited in terms of capacity. Private care was just out of pocket. Throughout the 70s and 80s, with economic stagnation, and structural adjustment programs there was an increase in reliance on user fees. Those started small and typical in hospitals and for medicines, but by the late 80s there were really user fees associated with almost every health service in the public sector. That helped launch a decade of experimentation with community based health insurance schemes. Over two hundred of these schemes were created. They varied in terms of benefits policies but typically had pretty limited benefits policies. In terms of coverage of the population, they only ever reached about 1 percent of the Ghanaian population.



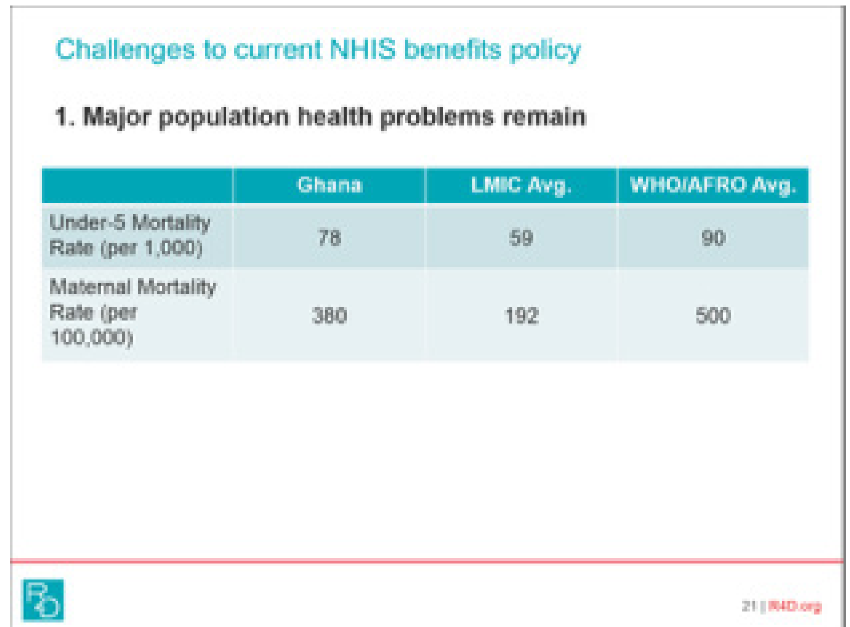
CURRENT NHIS BENEFIT POLICY

(Min 54:55)

NATHAN BLANCHET

Because of this increasing crisis of user fees and financial access to care and a very important election that was going on, the NHIS was born in 2003. For mostly political reasons, the benefits policy was set extremely generously. It was set to cover, what they called, 95 percent of diseases conditions in the country. Because the political tensions over the past user fees, which were called the ‘cash and carry system’, were such a big part of the political liability and the political promise that the political party at the power at the time, in 2003, had made, they thought they had no choice but to have zero copayments associated with the benefit package. Importantly this was one benefits package for all Ghanaians. They did not have some of the historical issues that we see in Latin America, with historically entrenched social security institutions for different segments of the population. This really started off as a single payer nationally from the beginning.

The benefits policy was mostly an implicit one but it had a little bit of explicitness to it. It is set to cover 95% of the disease conditions. In the law that was originally passed they actually listed what the benefits package would be, but only used very broad categories to describe what that included. The broadest categories in the law are three or five sub bullets for each one, which describe them in a little bit of more detail but nothing like a comprehensive, explicit list of benefits. The one thing that is most explicit is a list of exclusions and that includes things like high cost surgeries, HIV-Aids medicines are not included, because they are covered under the National Aids Program, dialysis, cosmetic surgery etc. Yet, it is a fairly limited list. That is what the current situation is. For the first ten to twelve years of NHIS making adjustments to the benefits policy was simply off the table politically. No one wanted to talk about co-payments or restrictions to benefits. For a long period, it was politically untenable to talk about making adjustments to that unless you would promise more.


Challenges to current NHIS benefits policy

1. Major population health problems remain

	Ghana	LMIC Avg.	WHO/AFRO Avg.
Under-5 Mortality Rate (per 1,000)	78	59	90
Maternal Mortality Rate (per 100,000)	380	192	500

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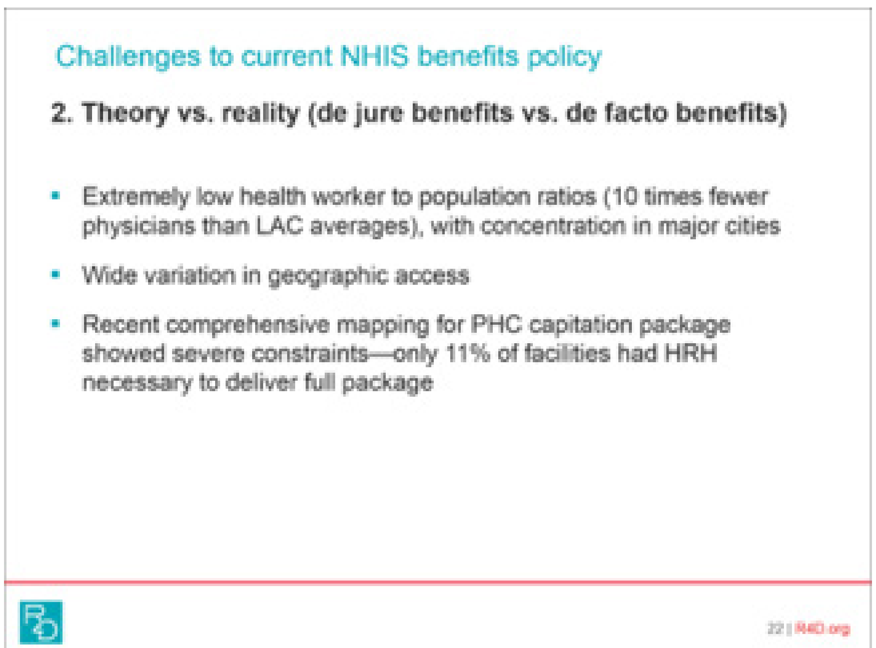
CHALLENGES TO CURRENT NHIS BENEFITS POLICY

(Min 57:59)

NATHAN BLANCHET

I would like to highlight that there is now increasing recognition, acceptance and transparency about at least three big problems, or probably more:

1) the major population health problems still remain, for example the under-five mortality rate and maternal mortality.



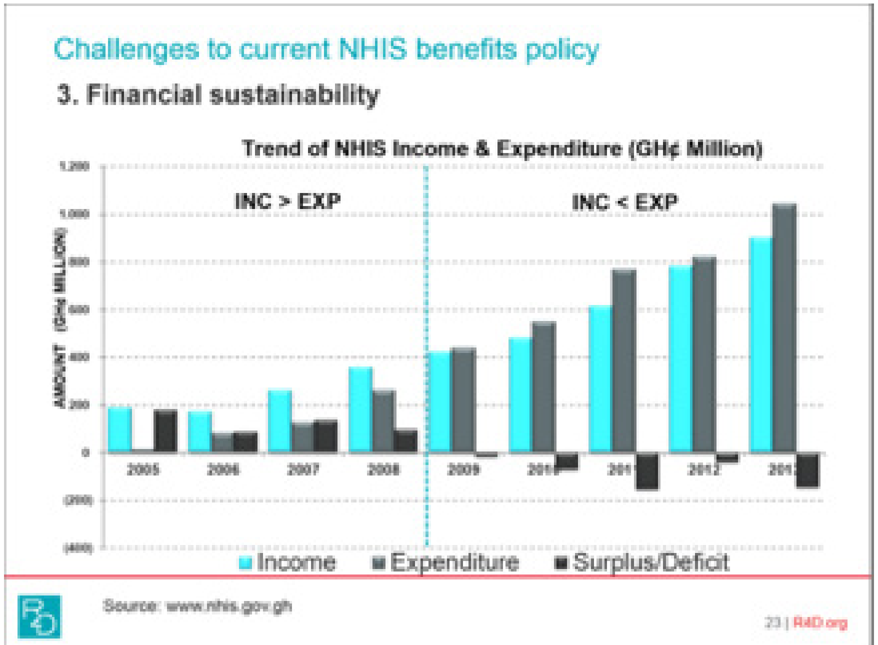
THEORY VS. REALITY

(Min 58:20)

NATHAN BLANCHET

2) There is a large difference between theory and reality, the de jure benefits listed in the law versus what is de facto available, extremely low health worker population ratio with a concentration in the city and a wide variation across the country in physical access to services.

One example is that as Ghana was making its switch to capitation payment for its primary care package they did a very extensive capacity mapping of providers and found that only 11 percent of the facilities had very basic human resources available necessary even just to deliver even just this limited primary care package. For example, caesarian sections are available in the benefits package but if there is no anesthesiologist at a hospital then obviously that is not truly available. imbalances in decision-making and improving capacity for evidence based policy making.

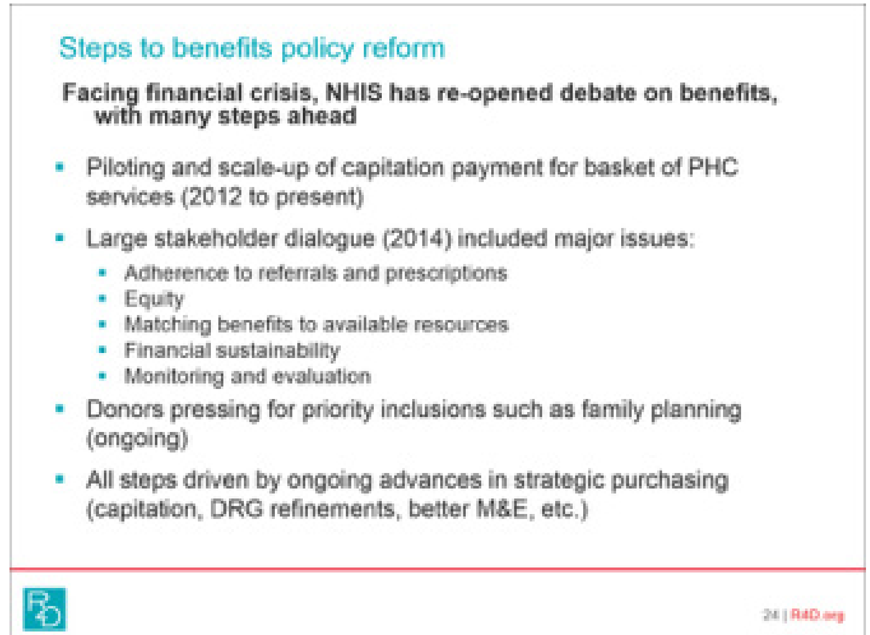


FINANCIAL SUSTAINABILITY

(Min 59:25)

NATHAN BLANCHET

3) The problem that gets the most attention though is the financial crisis that NHIS finds itself in. That is what the graph shows. In the early years they enjoyed a situation where, partly because of the slow enrollment at the beginning, they had tax money coming in but not much money going out in terms of paying claims. That has changed over time. As of 2009, and beyond, expenditures are outstripping the income. This is an urgent problem that they are trying to address and because of this crisis, benefits policy is now back on the table and people are talking about it more openly.



STEPS TO BENEFITS POLICY REFORM

(Min 1:00:18)

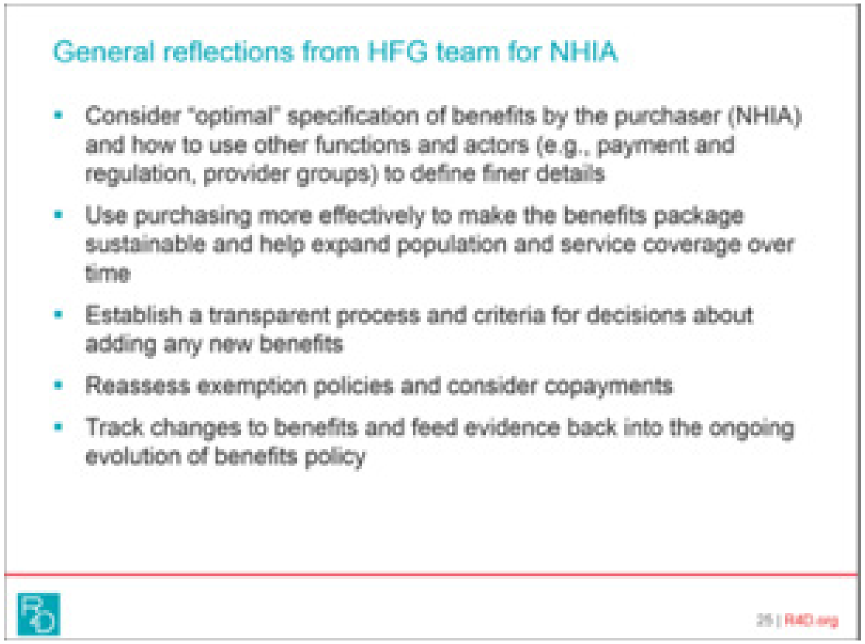
NATHAN BLANCHET

Ghana is now going through several steps. Since Ghana is facing this crisis they are taking several measures:

1) they are switching to capitation payment at the primary care level. That has involved extensive negotiations about what would be in the basket of primary care or not. They have gotten lot of push back from providers and pharmaceutical companies to not include certain services in that capitation basket.

2) A large stakeholder dialogue of 200 to 300 people was held last fall. I participated in that, along with several international facilitators, and many stakeholders of Ghana´s health system to talk about several issues related to benefits policies, from adherence, to referral systems, to the financial sustainability problems, how to better monitor and evaluate and what options they might have looking at the options available from other countries.

As they go forward probably the most important point is that they will be revising benefits policies as part of revisions of strategic purchasing, including capitation. They are considering other mechanisms like global budgets or some kind of budget neutrality factors in the way they pay providers. All of those will need to be done in tandem with changes to benefits policies.



GENERAL REFLECTIONS FROM HFG TEAM FOR NHIA

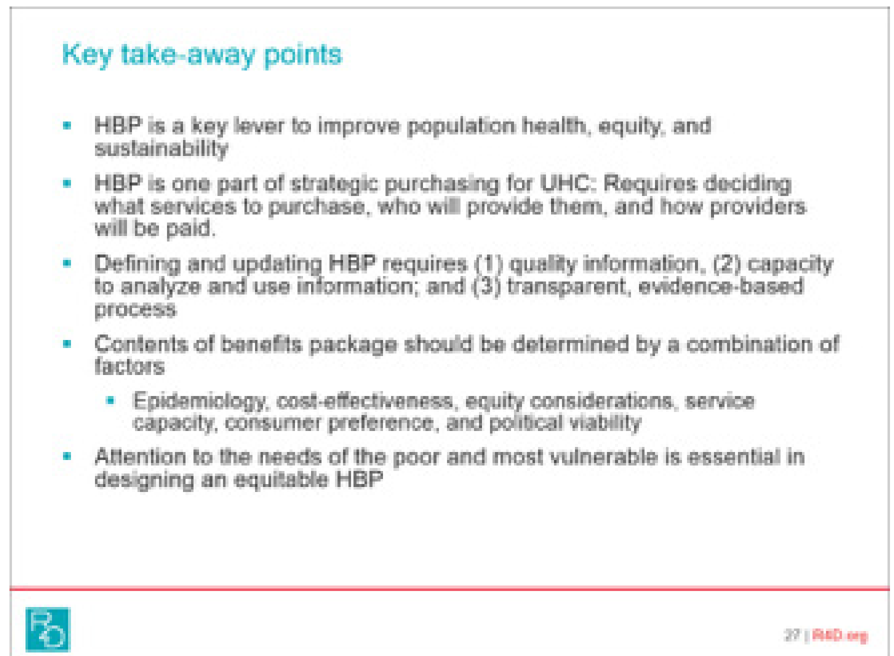
(Min 1:02:10)

NATHAN BLANCHET

Our health financing and governance team made some suggestions and reflections for the NHIA to consider.

The first one underlines the link to strategic purchasing. Let us think about the optimal specification by the purchaser in NHIA, and how other functions might be used to get into more details. The question is: How explicit do you make a benefit policy? In the capitation and primary care sake, what the NHIA is able to do, is to avoid some of those decisions, by saying just broadly what is expected to be delivered by primary care providers. Then it shifts the more clinical level decision making to medical provider associations, who can be focused on standard treatment protocols and what is the best types of service in what type of facilities.

The NHIA will of course want to retain some clinical audit-type authority. This concept really is about thinking about payment, bundled payment, and making sure that is aligned with how much you need to specify the benefits. There may be ways of using those payment mechanisms and other regulatory mechanisms to sometimes avoid the purchaser needing to come up with a very comprehensive, detailed and explicit list.

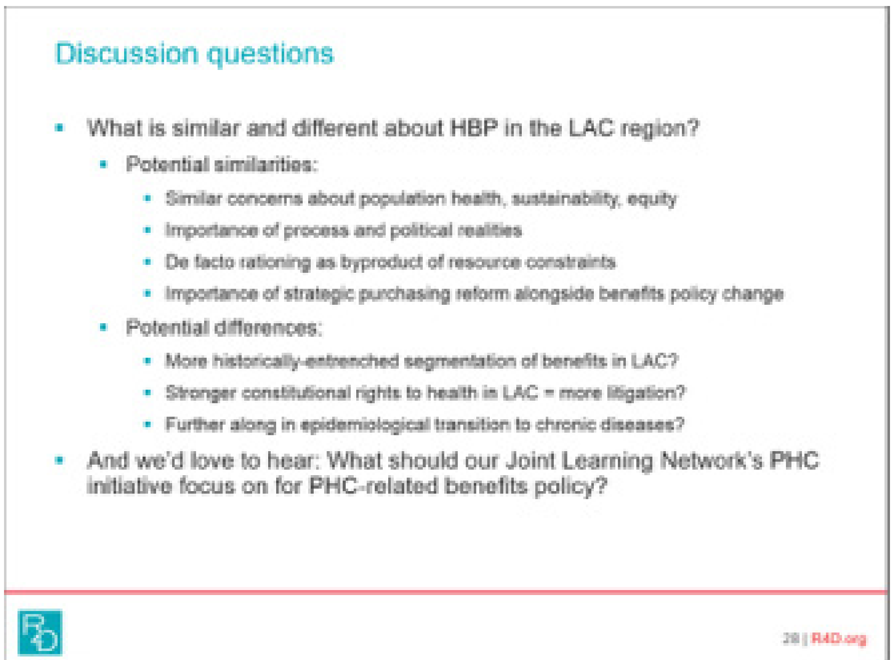


KEY TAKE-AWAY POINTS

(Min 1:04:15)

NATHAN BLANCHET

Several key take away points are presented on this slides, as we reflect on Amanda's points and my experience from Ghana. We have talked about these extensively.



DISCUSSION QUESTIONS

(Min 1:04:40)

NATHAN BLANCHET

The final slide shows our brainstorming of some discussion questions. We are very interested in hearing reactions of this audience that focuses on Latin America about what are some potential similarities or differences in the region.

(Min 1:06:20)

URSULA GIEDON

I think it is probably very hard to compare Asia and Africa to Latin American in general. Latin America is very heterogeneous. I therefore find it difficult to answer overall questions.

Translated from Spanish:

I thought the presentation regarding Ghana was very interesting. The comparisons that we can make are more between pairs of countries. I think that in the case of Ghana you show some very important issues. I will only mention

some. One that we are very familiar with, especially in Colombia, is the impact of politics on the scope of the benefits package. Amanda and Nathan mentioned that there is a tradeoff between political pressure and sustainability in the medium term. Another issue that we have always been underlining in our conversations is the difference between the benefits plan and the practice. There can be a huge gap between them. If there are no concrete measures to close this gap, a benefits plan is simply a political issue.
Another issue I would like to point out, is regarding the example you gave of Ghana, and how a financial crisis can be an opportunity to rethink the benefits plan. I think there is many countries in this region which have excessed the promises made to the population. Only in the moment when we face a financial crisis we are maybe rethinking what we can really offer.

QUESTIONS

(Min 01:09:36)

QUESTION FROM URSULA GIEDON

"Which do you think is the optimal level of detail for a benefits policy plan, in a system, where the responsibility of providing the benefits plan is not only limited to one health insurance provider, but a number of different health insurance providers?"

NATHAN BLANCHET

I think it is a very difficult question. I don't mean to be avoiding the question. But I really think that there is not one right answer. I think it is important to understand different perspectives.

From a very personal perspective, I have health insurance and I like being able to see exactly what I am entitled to. From a consumer's perspective, I like that there is a pretty detailed level of specificity in the plan and that I can choose. Although, not as specific as all the payment codes that health providers use. Yet, it gives me a very good idea about what I am going to be entitled to, and what I am not going to be entitled to.

On the flipside, from the purchaser's perspective, considering Ghana's NHIA for example, I really think that it does make sense to have some limits to the explicitness that they should be expected to list in the benefits policy. This is partly just a capacity and skill level question. The NHIA does not have as much experience and skill as the provider associations would have in Ghana to get into the level of what is clinically best or not.

From a capacity perspective, and a political strategy, they want to find that happy medium to give enough detail. They are giving their beneficiaries the care that they think they are to be entitled to. They have some ideas about what good primary care should include. But stopping short of a clinical level of detail, and finding some mechanism to bring in the providers as partners, and have them play a role in understanding that there are resource constraints and defining what would be appropriate, and not appropriate.

That of course has to be done in tandem with whatever payment mechanism they are using. If they stick to fee for service, then they have to list things out in high level detail. As they go towards more bundled payment, such as capitation, I think they can get away with less level of detail. They put a little bit of more risk and responsibility on the providers. Of course they need good monitoring and evaluation systems to make sure that the beneficiaries are getting the kind of care that they need to get. Often times this is lacking. I hope this answer was not too ambiguous, but these are some perspectives that are important to consider.

(Min 1:13:15)

URSULA GIEDON

I think we have to think more about this question, and help countries to identify the key contextual factors that shape the answer in each case.

NATHAN BLANCHET

I will just add one more thing. At the big stakeholder dialogue in Ghana, I actually presented the case of Chile's AUGE reform as a very positive case, because having studied it a little bit, I find it very good in many ways. I told them that there is a process that involves technical criteria and social preferences, recognizes resource constraints, includes a process to revise it over time, and is able to prioritize certain services. There is an involvement of providers in specifying the very detailed clinical features that go with each of those priority conditions.

(min 1:15:25)

QUESTION FROM MANUEL ESPINOZA

"When you think of the structure of a health benefits plan, what would be the best in order to work towards UHC? Is it good to prioritize health problems, pairs of intervention health problems?

AMANDA FOLSON

I think this question is very closely connected to the question we were just discussing around optimal benefits, and related to the type of purchasing mechanism that the country is using. We are seeing evidence that countries are trying to move more towards bundling and less detailed categorization of services in their benefits plan, as they move towards more strategic purchasing mechanisms. I think this is a very important question. It would be good to get more evidence and experience, as we think in what is the optimal way to define the benefit.

(Min 1:17:07)

QUESTION FROM ANA LUCÍA MUÑOZ

"How did different stakeholders participate in the design of the benefits package in Ghana?"

NATHAN BLANCHET

In order to answer this question, you have to look at the political situation that launched the NHIS. The beginning design of NHIS started in a fairly technical way, dominated by a technocratic change team. They were looking at benefit policies of the previous community based health insurance schemes. They wanted to reflect that experience. That tended to be some basic outpatient care. There were things like snake bites that were very important to local populations in those schemes. The original technocrats really wanted to expand the community based insurance schemes over time organically. They had a slower, more organic growth strategy in mind, that would slowly add benefits, financing and coverage.

For very political reasons, and this is very well documented in the literature, that process was taken over by the political party that was nearing its re-election. Three things were needed: 1) a national program that was able to scale up immediately, 2) it had to be available for all Ghanaians, be big and bold, and cover most, or nearly all disease conditions, that Ghanaians had, and 3) it needed to be a clear break from the prior system that had been started by the previous party, which was a break from the community based insurance schemes. In reality they did leverage the previous community schemes to scale up more quickly but it really was a political decision to say: we want to cover 95%. Honestly, I have researched it quite a bit and I have never seen great documentation that the 95% mark was ever really measured. Sometimes they say it is 'disease conditions', sometimes it is 'burden of disease'. Those are different things.

There was a lot of dialogue with providers and with pharmaceutical companies, especially when it came to negotiating the fees, and the list of medicines that would be included. Those were areas where they had a more specific stakeholder dialogue. Yet, the very first decision was a political one to have a nearly comprehensive package.

CRITERIA

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