

Defining a health benefits package: More tips for emerging markets

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For countries that want to provide universal health coverage, defining the benefits package can be challenging. An analytical framework provides insights and action steps for emerging economies.

Providing universal health coverage for citizens is a pressing concern for most countries.¹ The process of getting there, however, is far from painless, especially for countries with emerging economies. Early in the journey toward universal coverage, policymakers in those countries must decide what will be included in their country's future health benefits package (HBP)^{2,3}—the type and scope of healthcare services that a national purchaser will buy from providers on behalf of its beneficiaries.⁴ In the absence of a defined HBP, a country cannot ascertain whether universal coverage has been achieved.

Most emerging nations striving to provide universal health coverage belong to one of two groups. The first group consists of countries that need to develop an HBP from scratch. The second group includes countries that already have some sort of health insurance system (public or private) but need to revise their HBP in line with population needs and available financial resources.

Regardless of which group a country falls into, achieving consensus about the HBP is likely to be difficult.^{5,6,7} The country must define (or redefine) the shape of its HBP and determine what it can afford. For a country starting from scratch, other critical problems to be overcome include defining the eligible population⁸ and determining both how to secure the financial resources necessary to provide sustainable coverage⁹ to eligible individuals and how to guarantee delivery of benefits across the network of providers.

For a country in the second group, the critical decisions focus on what should be added to, or subtracted from, the existing HBP to ensure that eligible individuals have access to the set of services that best meets their healthcare needs within budgetary constraints. Subtractions from an HBP can be especially contentious, but postponing needed reforms could eventually threaten the health insurance program's fiscal stability.¹⁰

For all countries, a key question when determining affordability is reimbursement: What levels are appropriate based on providers' costs? Healthcare providers generate debts; they cannot continue to deliver services if they cannot pay those debts. If payment from the country's health insurance program is inadequate or absent, providers may attempt to shift payment responsibility to patients (thus increasing the number of individuals and households that will be impoverished because of healthcare costs) or stop providing the services.¹¹ Yet, policymakers must often make reimbursement decisions in the absence of detailed information about providers' costs in their countries.

Thus, when designing a new HBP or redesigning an existing one, policymakers in emerging economies must make sure they have a fair and transparent process for making a complex series of decisions—and the process must take data gaps into account.^{12,13} To help them

with this effort, we have developed a unified framework with four dimensions. This framework is flexible enough that countries in both groups can apply it to their situation (Exhibit 1). It can help policymakers develop their initial ideas and identify areas in need of deeper investigation. In addition, it can enable them to develop the detailed insights necessary to ensure that they can allocate their countries' scarce healthcare resources wisely.

EXHIBIT 1 A unified framework can help policymakers define the final shape of a health benefits package (HBP)

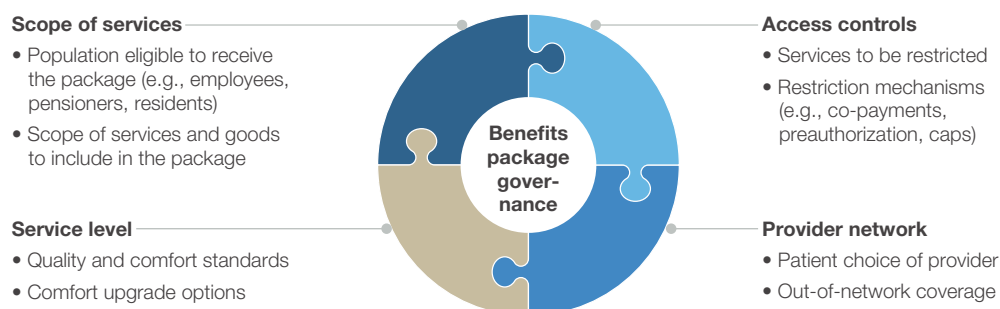
Two groups	Key questions	Unified framework	Output	Outcome
Starting from zero: Setting up a new HBP	<ul style="list-style-type: none"> • What is the eligible population? • What to include in the HBP? • How to finance the HBP? • How to secure delivery across providers? 		Health benefits package	Universal health coverage
Revising the existing HBP	<ul style="list-style-type: none"> • How to optimize? • What to add or exclude from the HBP? 			

How to define the HBP

The framework we developed captures the four dimensions of universal health coverage: the scope of the services, access controls to benefits, comfort and quality standards,¹⁴ and the provider network (Exhibit 2). Fundamental to this framework are two things:

- International benchmarking, which provides a way to compensate for the scarcity of data in many emerging economies (see the sidebar on p. 10 for more details).
- A strong governance system—that is, a transparent process led by a group of respected people who are responsible for creating, maintaining, and updating the HBP from time to time.¹⁵ At a minimum, this advisory committee should include staff members from the ministries of health and finance, medical experts, and actuaries. (We discuss the importance of a strong governance system, and the additional people who should be involved, later in this article.)

EXHIBIT 2 Defining the “shape” of the health benefits package requires design choices across four dimensions



Sources: Builds on the World Health Organization's *Health Financing Country Diagnostic* report (2016) and expert input

Within each of the four dimensions, our framework uses three steps in the design process (Exhibit 3):

- Define the shape—map out the high-level design.
- Detail the design.
- Decide which services are in and out.

All four of the dimensions must be considered before any final decisions can be made. Most countries start and finish with the first dimension—the scope of services to be included—and often give inadequate attention to the other three. As a result, they leave open many unanswered questions that may cause financial and delivery problems once the country begins to implement the HBP.

EXHIBIT 3 Within each dimension, design choices must be made at increasing levels of granularity

Dimensions	Define the shape	Detail the design	Decide what's in and out
Scope of services	<ul style="list-style-type: none"> • What is the eligible population? • Will the package be restricted, comprehensive, or expanded? • Which are the key services requiring further analysis? 	<ul style="list-style-type: none"> • What categories of services will be included or excluded based on international benchmarks (e.g., in vitro fertilization, dental implants)? 	<ul style="list-style-type: none"> • Based on health technology assessments and actuarial modeling, which procedures, drugs, devices, and other services will be included or excluded?
Access controls	<ul style="list-style-type: none"> • Will there be significant or minor access restrictions? • If so, what type(s) of restrictions (e.g., co-payments, preauthorization, caps) will be imposed? 	<ul style="list-style-type: none"> • Which restrictions will be imposed at the system level by imposing restricted network of providers, and which will be applied at the service level (e.g., what is in, and what is out)? 	<ul style="list-style-type: none"> • What specific access restrictions will be applied to expensive procedures, drugs, medical devices, and other services?¹
Service level	<ul style="list-style-type: none"> • Will minimum standards for quality and comfort be specified? • Will comfort upgrades be permitted? 	<ul style="list-style-type: none"> • What will be the inpatient comfort standards and options?² • What will be the criteria for defining device quality standards?³ 	<ul style="list-style-type: none"> • Which standard of devices and materials will be funded?
Provider network	<ul style="list-style-type: none"> • Will some access to private-sector providers be permitted? • If so, what approach will be used to limit access? 	<ul style="list-style-type: none"> • For which services will access to private-sector providers be permitted? 	<ul style="list-style-type: none"> • Which private-sector providers will be added to or removed from the network?
Governance	What is the process?	Who is involved?	What are the criteria?

¹Restrictions in form of caps are typically applied for expensive procedures, drugs, and device, because of their high cost.

²Single or shared room with two or four beds.

³The cost of specific medical devices (e.g., orthopedic prostheses) may vary depending on the brand. Brand-name devices and drugs are usually much more expensive than private-label devices and generic drugs. A country can opt to impose standards that control the quality of devices and drugs, regardless of the brand.

Dimension 1. Scope of services

The initial step is to establish the high-level shape of the HBP. The key questions at this stage are:

- What is the eligible population?
- What type of benefits package—basic or comprehensive—can the country financially afford?
- Which health services require deep analysis?

Addressing the first two questions requires an accurate understanding of a country's available financial resources. Not all countries can afford the same type of health benefits for their citizens, nor are they able to provide similar benefits to non-nationals (expatriates). However, an international benchmarking exercise can help policymakers develop an initial idea of who and what should be included—and what is affordable—based on the choices other countries have made. Many emerging economies have already undertaken similar exercises, and their findings can help policymakers develop a sense of what is possible. This exercise does not prevent policymakers from conducting additional analyses, but it makes possible an efficient use of time and resources.

The next two steps drill down into the details of the potential suite of services to determine what should be included or excluded. The international benchmarking exercise provides insights here as well. Typically, benchmarking enables policymakers to define three groups of services. The first can be referred to as “no-brainers”—services that are clearly cost effective and affordable enough that they must be included in the HBP (e.g., preventive, primary, and emergency care). The second group consists of services that should be excluded from the HBP because their costs are too high or evidence of their effectiveness is insufficient.

In the third group are services in the middle—those that require further analysis. The services that fall into this category often vary among countries, depending on their healthcare systems' stage of development. For example, many countries are moving toward adoption of value-based care models¹⁶ that foster integrated care delivery across providers. In these models, the key measure is patient outcomes, not the volume of services delivered.¹⁷ This model fosters innovation in healthcare delivery and stimulates providers to offer better-aligned, comprehensive, and higher-quality care to patients. However, a country with a less advanced healthcare system might not yet have all systems and required infrastructure in place to introduce these models.

A subgroup within the advisory committee will need to conduct detailed assessments, including complex actuarial modeling. (For more details, see the section below on governance.) The output from these assessments can help this subgroup determine three things:

- The strength of the evidence supporting the various services in the third group.
- How great the need for those services is likely to be in their country.
- The likely cost of delivering those services, as well as the cost of the no-brainer services already included in the HBP (for more details on the actuarial model, see the sidebar on p. 10).

Once the subgroup members have finished their evaluations, they should discuss their findings with the rest of the advisory committee. Armed with this information, the committee can determine which procedures, drugs, devices, and other services should—and should not—be included in the HBP, and then put forward their recommendations for final approval to the executive decision makers (in many countries, these are the ministers of health and finance). The decision makers may approve the recommendations in full or choose to veto some of the specific proposals.^{18,19}

Dimension 2. Access controls

The second dimension helps the advisory committee determine whether any access controls on use of the services in the HBP are appropriate. This decision must consider both what is culturally appropriate within their country and what is financially affordable. The following questions should be asked first:

- Will any significant or minor access controls be imposed?
- If yes, what type of access controls are preferred?

International benchmarking can be a good guide to answering the first question because it allows policymakers to review the types of access controls used most often in comparable countries. The access controls may include co-payments, referral requirements, and caps on the annual use of specific services. Decisions about which control measures should be used, and when they should be applied, vary among countries, in part because of differences in how citizens perceive them and how well policymakers can justify their use.

Answering the second question requires perception analyses—investigations into the viewpoints of citizens, especially those who use health services (Exhibit 4). Large-scale, cross-sectional surveys can provide valuable insights about citizens' preferences and expectations for the HBP. If sufficient resources are available, the analyses should also include focus groups with carefully selected cohorts of users from different population segments and regions to assess their perceptions of different services. Other research can also be included if resources are available.

The results of the perception analyses can do more than just help policymakers determine when access control is appropriate—they can also help politicians defend the imposition of limits on use, since access controls often stir up controversy.

EXHIBIT 4 Perception analyses can reveal citizens’ attitudes about various benefit options

Data source	Objectives	Methodology	Rationale
Key methods			
1 User focus groups	<ul style="list-style-type: none"> Understand knowledge, attitudes, and experience of citizens across the four dimensions of the framework 	<ul style="list-style-type: none"> Focus groups with participants of different sexes, ages, and regions 	Engage end users in the process to better understand existence of standards variations across the country
2 Quantitative face-to-face survey	<ul style="list-style-type: none"> Understand pain points of current benefits package provision as perceived by general population 	<ul style="list-style-type: none"> Face-to-face interviews of about 20 minutes’ duration 	
3 Online survey	<ul style="list-style-type: none"> Give the broader public the opportunity to contribute to the health benefits package design Raise awareness of reform 	<ul style="list-style-type: none"> Multiple-choice online survey Open access via social media 	
Optional methods			
4 Patient associations	<ul style="list-style-type: none"> Understand main pain points of current health benefits package provision as perceived by relevant stakeholder groups 	<ul style="list-style-type: none"> Multiple-choice online survey Participation via email invitation only Less than 10 minutes’ duration 	Engage with patients and professionals to better understand their attitudes and experiences toward standards variations ¹
5 Physicians	<ul style="list-style-type: none"> Give stakeholder groups the opportunity to contribute to the health benefits package design 		
6 Medical associations			

¹ Many countries experience significant variations in standards in the provision of healthcare services, depending on the location of the providers and volume of services they deliver.

Dimension 3. Level of services

The third dimension focuses on the level of services delivered—the quality of care and degree of comfort offered to patients. Answering the following questions provides a good start:

- Should the HBP specify minimum standards for the quality and comfort of care?
- Should the HBP provide and permit upgrade options for comfort standards?

Once again, international benchmarking can help policymakers discover what comparable countries have decided. Most countries impose standards for assessing the quality of care, using specific evidence-based guidelines.

It is important to note that the agreed minimum quality of care that is delivered throughout the provider network should be the same for all patients, regardless of their type of insurance. Comfort standards are somewhat different, however—policymakers in many countries have chosen to allow providers to offer different levels of comfort to patients, who then have the option to purchase upgrades if they can afford to do so. (Whether comfort upgrades are acceptable depends in part on a country’s cultural norms.)

Comfort standards apply most often to the type of accommodations a patient receives while hospitalized. The HBP might guarantee all eligible patients equal access to a two-bed room or four-patient ward. Hospitals would be permitted to offer patients a private room, but the patients would have to pay extra for the upgrade.

Dimension 4. Provider network

The fourth dimension focuses on the network of providers—both public and private—that will be responsible for delivering the approved benefits package to the eligible population. Two questions must be considered first:

- Will services within the HBP be purchased from all providers, or will selective contracting²⁰ with private providers will be allowed?
- If so, what approaches will be used to define the type, volume, and cost of specific services, as well as access to them?

Many countries specify preferred providers—typically, public providers—that can guarantee delivery of the services in the HBP. However, for services that are highly specialized or experiencing increased demand (e.g., in vitro fertilization and cataract surgery), some countries extend the network to include private providers.

Because the provider network is so important to the success of an HBP, a well-defined and transparent process based on clear standards must be used when the initial network is created or when providers are to be added or removed from an existing network. In most cases, the standards should be developed based on the cost efficiency and quality.²¹

Effective governance

Defining or redefining an HBP is a demanding and politically sensitive process. A strong and effective governance system is essential for the effort's success, and thus it plays a central role in our framework.

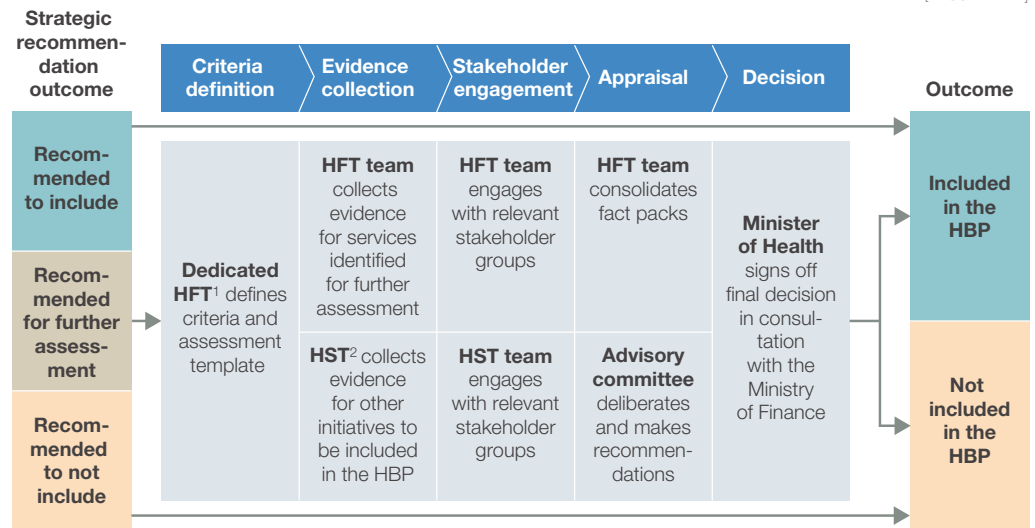
The advisory committee should be established by the country's relevant health authority, often the ministry of health. However, the ministry of finance should be well represented on the committee. In addition, the committee should include medical experts, actuaries and, if possible, patient representatives. In countries with an existing health insurance system, representatives from the insurer(s) should also be included.

To be perceived as legitimate, the advisory committee must be trusted by the country's citizens. Thus, the committee members should start by agreeing on a fair and transparent process to guide their assessments. Among the topics that must be decided: What principles will guide the decision-making process? How will evidence be collected—and from where? How can the evidence be evaluated in an unbiased manner?²²

The detailed investigations, including the technology assessments and perception analyses, are conducted by a subgroup within the committee. The subgroup has two components (Exhibit 5). The health financing team should be responsible for data collection—benchmarking, actuarial modeling, and surveying—and for managing the overall process of developing the HBP recommendation. The health services team should assess the evidence supporting the services that require further analysis, as well as any new initiatives or interventions (e.g., prevention services and enhanced IT support) that might be included in the HBP.

EXHIBIT 5 An advisory committee of health system stakeholders will make the final benefits package recommendation

[ILLUSTRATIVE]



HBP, health benefits package; HFT, health financing team; HST, health services team.

¹ Ministry of Health should form dedicated health financing team to be responsible for data collection and management of the overall process.

² In addition to the HFT, it is desirable to have a supporting team that will assess any new initiatives or interventions to be included (e.g. prevention services, enhanced IT support, etc.).

In practice, however, disagreements about prioritization often arise because of the varying perspectives of different beneficiary groups, as well as different provider types. For this reason, it is important that, early in the process, committee members engage with relevant stakeholders to understand their views—and to make sure that the stakeholders understand and support the approach being used for final decision making. These efforts are likely to fail, however, unless the advisory committee members agree to accept the outcome of the deliberation process—otherwise, it will not be seen as fair and legitimate.²³

Once all the research is complete, the advisory committee must assess each of the proposals and make final recommendations to the responsible health decision makers. They will then make the final choices about the HBP.

□ □ □

At the heart of designing an HBP is the problematic task of setting priorities for a country's health. Many approaches have been proposed to help countries develop clear answers about what should and should not be in their HBP, given their limited available healthcare resources. In 2014, for example, the World Health Organization released guidance to support decision makers in setting health priorities at national and subnational levels.²⁴ Despite the huge body of published literature, moral dilemmas and disagreements surrounding these questions remain.²⁵

We hope the framework presented in this article gives policymakers in emerging economies a set of useful tools and a practical methodology. The framework can be modified and adjusted for use in a country without much difficulty. Thus, it should prove useful to a range of countries facing similar challenges.

International benchmarking

Across emerging markets, countries struggle to secure strong and relevant data on their health systems. A key problem is resourcing; policymakers in those countries typically lack the capacity to collect the required information. Thus, they often have only limited insight into provider-level data (e.g., types of providers, types of hospitals, number of beds, and bed occupancy rates) or activity levels (the type and number of procedures, drugs, devices, and other services delivered to patients each year). Similarly, they are often unable to disaggregate their country's current health budget into spending on primary, secondary, and tertiary care (never mind specific types of care). Yet, this information is essential for the design or redesign of an HBP.

To overcome this problem, we have developed a practical approach based on rapid international benchmarking to help policymakers focus their efforts. The initial step is choosing an appropriate set of peers. Baseline countries should be selected according to their comparability to the home country in terms of their geography, culture, and economic situation, as well as the aspirations of their health systems. The selected countries must have publicly available HBPs that are explicitly defined within their public health insurance systems.

The next step is to determine what, if any, services are currently covered in the minimum packages offered by private health insurers in the home country. This information gives policymakers another point of comparison and may reveal services that could potentially be excluded from the HBP.

As discussed in the main article, benchmarking will fairly rapidly reveal which types of services are covered by most peer countries and thus should be included in the HBP, and which services are typically excluded and thus can be ruled out. Policymakers can then drill down to consider which specific services they will recommend for inclusion in the HBP. As part of this process, they must determine which services providers in their country will be able to deliver in practice. (This step requires a provider capability assessment, a topic that will be covered in a future article.)

Services that are not obvious candidates for inclusion or exclusion need to be investigated further—but, once again, other countries can provide useful information. For example, both the National Institute for Health Care Excellence in the United Kingdom and the German Institute for Quality and Efficiency have conducted detailed evaluations of a wide range of healthcare services. By taking advantage of the reports issued by these organizations, policymakers can avoid duplicating their efforts. And, as we discuss in the sidebar on actuarial modeling, other countries can often provide useful proxy information on costs.

Actuarial model

An essential component of any effort to define or redefine an HBP is the development of an appropriate actuarial model. For countries that are not starting an HBP from scratch, the actuarial model would, ideally, be based on cost and utilization data from public providers that are already part of the network. However, because the availability of such data is often limited in countries with emerging economies, proxies may need to be used. Countries that do not yet have an HBP will also have to rely on proxies, unless they have high-quality clinical data that can be used to conduct specific actuarial and costing exercises.

Acceptable proxies can include private-sector data (private providers tend to have much better data quality), if available in the home country, or data from other countries with similar demographic, epidemiologic, and economic structures. Another option would be to design a data collection tool or questionnaire to aggregate insights from a random sample of healthcare providers. However, this process is time consuming and requires considerable resources, and thus most policymakers are likely to undertake it only when proxies are not available.

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Endnotes

- 1 World Health Organization. *Health Systems Financing: The Path to Universal Coverage*. 2010.
- 2 An HBP can be explicit (the list of available services is specific and, often, how the services can be used is clearly defined) or implicit (the list of available services is broad and use is not specified). The decision about what type of benefits package is appropriate very much depends on the quality of available information in a given country.
- 3 Smith PC, Kalipso C. Should countries set an explicit health benefit package? The case of English National Health Service. *Value in Health*. 2017;20(1):60–66.
- 4 Glassman A et al. Defining a health benefits package: What are the necessary processes? *Health Systems & Reform*. 2016;2(1):39–50.
- 5 Van der Wees PJ et al. The relationship between the scope of essential health benefits and statutory financing: An international comparison across eight European countries. *International Journal of Health Policy Management*. 2016;5(1):13–22.
- 6 World Health Organization. *Making Fair Choices on the Path to Universal Coverage*. 2014.
- 7 Ham C. Priority setting in health care: Learning from international experience. *Health Policy*. 1997;42:49–66.
- 8 Countries may decide to provide an HBP only to citizens or to citizens and some or all non-nationals (expatriates).
- 9 Hediger V et al. Health system financing: Tips for emerging markets. McKinsey white paper. April 2018.
- 10 Clements B et al. *The Economics of Public Health Care Reform in Advanced and Emerging Economies*. International Monetary Fund. 2012.
- 11 Ensor T. Informal payments for health care in transition economies. *Social Science and Medicine*. 2004;58:237–246.
- 12 Ottersen T et al. A new proposal for priority setting in Norway: Open and fair. *Health Policy*. 2016;120:246–251.
- 13 Ubel P. *Pricing Life: Why It's Time for Health Care Rationing*. MIT Press. 2001.
- 14 “Comfort” here refers to the type of accommodations a patient receives while hospitalized (e.g., a single or non-single room). “Quality” includes six domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness (as defined, for example, by the US Agency for Healthcare Research and Quality or a comparable organization in another country).
- 15 Countries should plan to have a regular annual review and update of the benefits package, but special requests based on the latest available knowledge and evidence could be accommodated twice per year.
- 16 What is value-based healthcare? *New England Journal of Medicine: Catalyst*. January 2017.
- 17 The Netherlands, for example, now includes bundled payments within its primary healthcare benefits package to cover the full range of diabetes-care services for a period of one year. (See: How bundled health care payments are working in the Netherlands. *New England Journal of Medicine: Catalyst*. April 2016.)
- 18 Sparkes SP et al. Political strategies for health reform in Turkey: Extending veto point theory. *Health Systems and Reform*. 2015;1(4):263–275.
- 19 Veto power can be exercised by formal institutions with the authority to block the adoption of administrative or legislative policy proposals. (In most countries, both the ministry of health and ministry of finance have this power.) The main purpose of veto power is to prevent the creation of overgenerous benefits packages whose costs will go beyond the country’s financial capabilities.
- 20 Selective contracting is a mechanism healthcare insurers use to channel their enrollees to specified care providers, thus increasing the insurers’ bargaining position. (For more details, consult: Bes ER. Selective contracting by health insurers: the perspective of enrollees. *Netherlands Institute for Health Services*. 2018.)
- 21 Sinaiko A. How do quality information and cost affect patient choice of provider in a tiered network setting? Results from a survey. *Health Services Research*. 2011;46(2):437–456.
- 22 Norman Daniels has argued that a country’s policymakers often cannot agree on the principles that should guide the decision-making process for setting priorities because people often disagree about the principles

underlying such decisions; some prioritize the worst-off individuals in the society, while others emphasize individuals for whom the given treatment or service is most likely to have the best results. Faced with this dilemma, policymakers are often reluctant to make a determination of what is considered just and fair. In response, Daniels proposes that countries establish an objective process for setting priorities that reasonable people representing the health authorities would consider legitimate and fair. (See: Daniels N, Sabin J. *Setting Limits Fairly: Learning to Share Resources for Health*, 2nd ed. 2008. And Rid A. Just health: meeting health needs fairly. *Bulletin of the World Health Organization*. 2008 Aug;86(8):653.

23 Daniels N. How can we meet health needs fairly when we can't meet them all? Accountability for reasonable resource allocation. In Daniels N. *Just Health: Meeting Health Needs Fairly*. 1995.

24 Norheim OF et al. Guidance on priority setting in health care (GPS-Health): the inclusion of equity criteria not captured by cost-effectiveness analysis. *BioMed Central*. 2014;12:18.

25 Glassman A et al (eds.). *What's In, What's Out? Designing Benefits for Universal Health Coverage*. 2017.

