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Setting Priorities for Universal Health Care in Low- and Middle-Income Countries

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The problem: allocating scarce resources across competing priorities

A fundamental challenge for all health systems and health insurers is to allocate finite resources across the unlimited demand for health services. This is a rationing problem, regardless of whether it is explicitly addressed as such, because it requires active or passive choices about what services are provided to whom, at what time and at whose expense. Inevitably, some demand goes unmet, which is one source of the intense pressure to provide more services within any given resource envelope. Efforts to reduce waste, increase quality and improve efficiency are all responses to this pressure. Expanding health-care costs are another reflection of the same forces. A 2010 report by the Organisation for Economic Co-operation and Development (OECD) found that health spending growth exceeded economic growth in almost all OECD countries over the past 15 years. In the context of worsening fiscal positions in the global recession and greater demand for services because of ageing populations, the pressure on OECD health systems to deliver more care with greater efficiency is unprecedented.

The scarcity of health funding in low- and middle-income countries (LMICs) also increases the negative consequences of sub-optimal decisions on the uses of public subsidy or insurance premiums. Although 10 percent of the world economic product is spent on health, all LMICs together spend less than 3 percent of this total. Per capita annual public spending on health in LMICs ranges from a low of US$2 in Myanmar to a high of US1,200 in Equatorial Guinea. The variation is this range is enormous, but even the high end is dwarfed by spending in rich countries; annual public spending on health in the U.S. is over US3,602 per capita.

However, pushed by rapid ageing and growing economic prosperity and education levels, demand for health care is also on the rise, and public spending on health in LMICs is growing at pace. On average, LMIC public spending increased about 0.1 of a percentage point every 10 years between 1985 and 2010, which translates into an annual percentage change in real per capita terms of 3.4 percent for public spending on health. In some middle-income countries, growth in public spending is notable. In Turkey, for example, between 1981 and 2012, the average annual percent change in public spending on health was 11 percent. Likewise, South Korea was 10.1 and Mexico 4.5 percent.

Rapid growth in LMIC expenditure matters for two main reasons. First, significant quantities of additional funding are rapidly coming online and choices must be made on their use, choices that will determine the health system's impact on health and other outcomes, as well as the trajectory of future spending. Second, increased public expenditure has created a larger market for health-care products and services, one more attractive to industry than the historically small markets in LMICs. Industry marketing and advocacy are scaling up rapidly; in 2010, total emerging-market spending on pharmaceutical products was just over US200 billion.[1] Novartis and Roche generate nearly 25 per cent of sales from emerging markets. By 2020, UBS estimates that developed and emerging markets could be almost equal in size, driven by an expansion of state health-care coverage. Balancing the public interest with commercial interests will become increasingly complex.

It is therefore in LMICs that the need for better priority setting is greatest. Although many health technologies may be cost-effective when assessed against a health maximisation or financial protection goal, they may be

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[1] http://online.wsj.com/article/SB10001424052748704113504575264453499634626.html?mod=WSJ_Markets_section_Heard

unaffordable under a given budget constraint, forcing countries or insurers to say "no" to good value, effective technologies, or resort to inequitable implicit rationing methods.

One solution: health benefits plans?

To respond to these pressures, LMICs are developing new or improving policy instruments to set priorities for public or insurer spending on health. Health benefits plans (HBPs) have become increasingly popular and are defined by Velasco-Garrido *et al*.[2] as a description of "services, activities and goods reimbursed or directly provided by publicly funded statutory/mandatory insurance schemes or by national health services." At core, benefits plans describe not only "what" is to be provided but also "to whom" and "in what circumstances", and should therefore be at the core of all publicly funded health care, and ultimately progress towards universal health coverage. And ideally, an HBP is not merely a list or a set of decisions, but should also be understood as an on-going process that shapes resource allocation and its outcomes now and in the future ("how 'who gets what' is decided"). Therefore, a benefit plan also defines a specific list of contingent liabilities for its beneficiaries—and consequently contributes substantially to defining its costs as well.

Although readily defined, identifying and classifying HBPs in practice is not straightforward, and analysts may disagree on what might qualify. Within the group of health systems that describe the services, activities and goods reimbursed and/or directly provided with some detail, explicit HBPs come in many shapes and sizes. HBPs may be positive or negative lists, catalogues or fee/reimbursement schedules. They may have broad or narrow scopes in terms of types of technologies, disease control priorities or eligible populations. And HBPs may be detailed and granular, or provide a less specific overview or guidance on the nature and content of goods and services to be funded and provided.

Motivations to adopt HBPs vary. The World Bank's World Development Report 1993, the Commission on Macroeconomics and Health[3], and—most recently—the Global Health 2035 Commission[4] argue that HBPs can be successfully used to channel funding towards health-maximising products and services. New guidelines issued by the World Health Organization describe universal health coverage (UHC) as requiring the definition of "a comprehensive range of key services well aligned with other social goals."[5] Indeed, many countries planning UHC reforms use HBPs as a means to understand and mobilise expenditure requirements associated with coverage expansions. In health systems that separate payment and provision functions, some variant of HBP is required to set expectations, organise payment systems and hold providers accountable for service delivery. Still others have argued that HBPs are necessary as a means to spell out entitlements to the population as part of the right to health, and to determine what is not covered so that individuals can self-insure for uncovered risks where possible (and insurance markets can develop). The International Monetary Fund (IMF), the European Commission and the European Central Bank have recommended "streamlining" HBPs to countries in economic crisis as a means to reduce public spending on health in the context of a fiscal crunch, or to identify essential health benefits. As a result of these multiple motivations, health systems in at least 65 low- and middle-income countries currently use some form of HBP as a policy instrument, with differing levels of explicitness and effectiveness.[6]

But, while commonly invoked as a policy recommendation and used in practice, HBPs and their associated processes share in common a surprising lack of scrutiny and evaluation. Beyond the 2004–2007 HealthBASKET

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2 Velasco Garrido, M., Kristensen, F.B., Palmhøj Nielsen, C. and Busse, R. (2006) *Health Technology Assessment and Health Policy-Making in Europe*, European Observatory Studies Series No. 14, Copenhagen: World Health Organization Regional Office for Europe.

3 Commission on Macroeconomics and Health, Working Group 5 (2002). *Improving Health Outcomes of the Poor*, Geneva, Switzerland: World Health Organization.

4 Jamison, D. *et al.* (2013). "Global health 2035: a world converging within a generation." *The Lancet* 382(9908): 1898-1955.

5 World Health Organization (2014). *Making fair choices on the path to universal health coverage*, final report of the WHO Consultative Group on Equity and Universal Health Coverage, Geneva, Switzerland: World Health Organization.

6 Glassman, A. and Chalkidou, K. (2012). *Priority-Setting Institutions for Global Health Working Group Priority-Setting in Health: Building Institutions for Smarter Public Spending*, Washington, DC: Center for Global Development.

project in Europe, other limited literature[7] and a forthcoming study on OECD countries, there has been little comparative analysis and forward-looking guidance specifically targeted to low- and middle-income country settings. *Health Benefits Plans in Latin America* by Giedion *et al*.[8] is a notable exception that explores motivations, scope, coverage and organisation of plans in seven Latin American countries, and analyses achievements and challenges. Further, work from Thailand on using health technology assessment (HTA) to inform coverage decisions[9] and to design a benefits plan in reproductive health[10], from Chile on the plan of universal guarantees (AUGE)[11] and from Mexico on the use of benefits plans for resource mobilisation and financial protection[12] have helped illustrate the potential of HBPs to deliver health system objectives. Literature and experience on priority-setting and resource allocation in general, as well as HTA, cost-effectiveness analysis, evidence-based/informed policy and medicine, clinical guidelines, comparative effectiveness research, systematic reviews and impact evaluation are also closely related and relevant areas, but have not been tightly linked to the process and practice of HBP design, adjustment and evaluation.

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

These questions require further analysis and will form part of a new effort led by NICE International[13] to understand how to better support LMIC governments and other payers in their efforts to set priorities on the path to universal health care.

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7 Schreyögg, J., Stargardt, T., Velasco-Garrido, M. and Busse, R. (2005) "Defining the 'Health Benefit Basket' in nine European countries: Evidence from the European Union Health BASKET Project." *The European Journal of Health* Economics 6(suppl 1): 2–10.; Stolk, E. A. and F. F. H. Rutten (2005). "The "Health Benefit Basket" in The Netherlands." *The European Journal of Health Economics* 6(suppl 1): 53–57.; Mason, A. (2005). "Does the English NHS have a 'health benefit basket'?" *The European Journal of Health Economics* 6(suppl 1): 18–23.

8 Giedion, U. Bitrán, R. and Tristao, I. (2014) *Health Benefits Plans in Latin America*, Inter-American Development Bank.

9 Mohara, A., Youngkong, S., Pérez Velasco, R., Werayingyong, P., Pachanee, K., Prakongsai, P., Tantivess, S., Tangcharoensathien, V., Lertiendumrong, J., Jongudomsuk, P. and Teerawattananon, Y. (2012) "Using health technology assessment for informing coverage decisions in Thailand." *Journal of Comparative Effectiveness Research* 1(2): 137–146.

10 Teerawattananon, Y. and Tangcharoensathein, V. (2004) "Designing a reproductive health services package in the universal health insurance scheme in Thailand: match and mismatch of need, demand and supply", *Health Policy and Planning*; 19(suppl. 1): i31–i39,.

11 Vargas, V. and Poblete, S. (2008). "Health prioritization: the case of Chile." Health Aff (Millwood) 27(3): 782-792.

12 González-Pier, E., C. Gutiérrez-Delgado, *et al*. (2006) "Priority setting for health interventions in Mexico's system of social protection in health", *The Lancet*, 368(9547): 1608–1618.

13 *http://www.nice.org.uk/about/what-we-do/nice-international*