



**JOINT
LEARNING
NETWORK**
For Universal Health Coverage

Revisiting Health Financing
Technical Initiative
Efficiency Collaborative

MAKING EXPLICIT CHOICES ON THE PATH TO UHC: THE JLN HEALTH BENEFITS PACKAGE REVISION GUIDE





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Glossary

Actuarial analysis (applied to HBP)	The application of mathematical and statistical methods to make educated predictions about HBP utilization and financial information while recognising sources of risks and uncertainty. ¹
Budget impact analysis (BIA)	Analysis used to estimate the likely change in expenditure to a specific budget holder resulting from a decision to reimburse a new healthcare service or some other change in policy at an aggregate population level. ²
Cost-effectiveness analysis (CEA)	An economic evaluation involving a comparison of several options, in which costs are measured in monetary units, then aggregated, and outcomes are expressed in natural (nonmonetary) units. ³
Costing method	Methodologies for measuring and valuing resources for the costing of health services. They include, among others, activity-based costing, average costing, nominal costing, and standard costing. ⁴
Costing study	The collection of data on costing information that can be used to inform policy and setting rates. ⁴
Costing system	The process of collecting and verifying cost data, the stage of development of the reimbursement system, and the regulation around the costing methodology used. ⁴
Crowding out or displacement of health benefits	An expansion of an HBP with low-priority services may induce a reduction in spending on existing high-priority services. This may translate to shortages of personnel and/or materials and ultimately affect the quality of care, create waiting lists, or even lead to unavailability of the latter services.
Deliberation	The critical examination of an issue involving the weighing of reasons for and against a course of action that usually involves a group of people that represent different stakeholders. ⁵
Delphi method	A structured communication technique or method to systematically aggregate expert opinion. ⁶
Disability-adjusted life year (DALY)	A time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability. One DALY represents the loss of the equivalent of one year of full health. ⁷
Disease burden	The impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators. ⁸ It is often quantified in terms of quality-adjusted life years (QALYs) or disability-adjusted life years (DALYs).
Disinvestment	The process of partially or completely withdrawing health resources from any existing healthcare practices, procedures, technologies, or pharmaceuticals that are deemed to deliver little or no health gain for their cost and thus are not efficient health resources allocations. ⁹
Equity	Equity in health relates to fairness in the distribution of health across individuals and is rooted in ethical principles of distributive justice: its application recognises the importance of not only maximising health gains but also achieving a fair distribution of these gains. ¹⁰
Evidence-informed deliberative processes (EDPs)	An approach for guiding legitimate decision making based on deliberation between stakeholders to identify, reflect, and learn about the meaning and importance of values, informed by evidence on these values. ¹¹
Explicit health benefits package	A well-defined and affordable set of health services that is available to a population. Well-defined means that it is clear who is entitled to what kind of services. Affordable means that sufficient financial, human, and material resources are available to provide all included health services at desired coverage levels.
Financial risk protection	Prevention of a person's or household's catastrophic health-related out-of-pocket expenditure. ¹²
Fiscal space	Room in a government's budget that allows it to provide resources for a desired purpose, such as an HBP revision, without jeopardizing the sustainability of its financial position or the stability of the economy. ¹³
Fiscal space projection	Predicting the expected changes in fiscal space required over a set time period using a variety of methodologies.
Health benefits package (HBP)	The selection of health services that is being provided, at a certain coverage of costs and of population.

Health benefits package revision	The process of evaluating and updating the HBP in terms of coverage of services, populations, and cost, and in terms of its implementation mechanisms, through a review of either the whole package, a partial package, or of individual services.
Health policy dialogue	A discussion, ideally among a comprehensive range of stakeholders, within and beyond government, including civil society organizations, the private sector, and health professionals and academics, within the health and other sectors, which is critical to increasing the likelihood that national policies, strategies, and plans will be appropriately designed and implemented and yield the expected results. ¹⁴
Health technology assessment (HTA)	A multidisciplinary process that uses explicit methods to determine the value of a health technology at different points in its lifecycle. The purpose is to inform decision making to promote an equitable, efficient, and high-quality health system. ¹⁵
Implicit health benefits package	A form of HBP which is difficult to implement in practice because i) services are not well-specified which may raise doubts over the precise entitlements people have, and/or ii) the package as a whole is aspirational which means it is not clear whether sufficient financial, human and material resources are available to provide all included health services at desired coverage levels.
Implicit rationing	Lack of access to services due to capacity restraints.
Incidence	The number of new cases of a disease during a specified time period. ¹⁶
Incremental cost-effectiveness ratio (ICER)	A summary measure representing the economic value of an intervention compared with an alternative (comparator). ¹⁷
Institutionalization	The embedding of certain rules and norms, and associated actions and processes, within a health system. ¹⁸
Multi-criteria decision analysis (MCDA)	An umbrella term to describe a collection of formal approaches that seek to take explicit account of multiple criteria in helping individuals or groups explore decisions that matter. ¹⁹
Multisite costing study	Analyses of cost and service volume data collected from a sample of healthcare delivery sites. ²⁰
Positive and negative lists in HBP	A positive list comprises services that are included in the HBP. A negative list states services that are excluded from the HBP.
Prevalence	The proportion of persons in a population who have a particular disease or attribute at a specified point in time or over a specified period of time. ²¹
Quality-adjusted life year (QALY)	A measure of health that reflects the quality of life. One QALY is equal to one year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). ²²
Reference case	Summarises the guidance as to the planning, conduct, and reporting of economic evaluations. ²³
Stakeholder	A person, group, or organisation that has certain interests in or concerns about a particular topic (e.g., composition of a health benefits package).
Stakeholder involvement	An iterative process of actively soliciting the knowledge, experience, judgement, and values of individuals selected to represent a broad range of direct interest in a particular issue, for the dual purpose of creating a shared understanding and making relevant, transparent, and effective decisions. ²⁴
Universal health coverage (UHC)	A situation in which all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. ²⁵
Unmet need	A condition for which there exists no satisfactory method of diagnosis, prevention, or treatment. ²⁶
Utilization	Usage of services under the HBP.

* The Glossary includes definitions from established international sources to the extent available. In other instances, definitions are developed by the authors.

Executive summary

Many countries around the world strive for universal health coverage (UHC) to provide the health services their populations need without causing financial hardship. A health benefits package (HBP) is a central policy instrument for countries to achieve this, as it defines the coverage of services, the proportion of the costs that are covered, and who can receive these services. Such HBPs can guide both the delivery of care and the associated resource allocation, including human resources, provider payment, procurement, and budgeting. HBPs essentially help countries make commitments to their populations in terms of the services citizens can expect to be covered.

Once developed and implemented, an HBP should not be static. It must be a living instrument that should be regularly revised to suit evolving health needs such as changing disease burdens, fluctuating budgets, and the emergence of new services, and to correct for implementation challenges. Revisions ensure that the package is up-to-date and delivered appropriately and that available resources are used efficiently and wisely. However, a recent review of HBPs in low- and middle-income countries (LMICs) shows that most packages have not been revised substantially.

This guide supports LMICs in revising their HBPs and was developed based on the experiences of 18 countries from around the world,^a most of which are represented in the Joint Learning Network Efficiency Collaborative (JLN EC). The guide was jointly produced with facilitators from Radboudumc and the Center for Global Development (as part of the International Decision Support Initiative – iDSI) and the World Bank, with input from country-level practitioners representing 14 countries from the JLN EC. Country experiences were captured through a process of multiple engagements: (i) a survey among technical staff and decision makers involved in the management of HBPs in 14 LMICs in Africa and Asia, (ii) semi-structured interviews in 11 of those countries, (iii) a workshop in India with several EC members to acquire further insights into their HBP revision process, (iv) submission of documented experience by individual countries, and (v) a review of the literature.

We define an HBP revision as the process of evaluating and updating the benefits package in terms of coverage of services (e.g., the entitlements), cost or rates, beneficiaries, and its implementation mechanisms. While we acknowledge the large challenges in HBP implementation, this guide focuses on the former activities, especially on how countries can best revise their HBP in terms of service coverage.

The guide is organized according to the following six broad questions and corresponding chapters.

What are the countries' experiences of HBP revision? (Chapter 2)

Survey and interview findings reveal a wide breadth of experiences in HBP development, implementation, and revision across countries. HBP revisions are scarce, and few countries have processes and structures in place to periodically review their package. EC members developed and revised their HBPs at different times, but all found challenges upon implementation. Challenges were often linked to insufficient consideration of financial, human, and infrastructural constraints.

What is important in HBP revision? (Chapter 3)

We identified five principles to HBP revision: HBP revisions should be seen as an evolutionary process; aim for universal coverage of existing priority services before expanding the package; disinvest from low-value services; ensure the revisions to the package are costed, within budget, and appropriately resourced; institutionalize periodic revisions to help stay on the path to UHC.

^a The 18 countries consist of 14 countries from the JLN (Bangladesh, Ethiopia, Ghana, India, Indonesia, Kenya, Laos, Malaysia, Mongolia, Nigeria, Philippines, South Africa, Sudan, Vietnam) and four countries from the literature (Chile, Iran, Pakistan, Thailand).

How to organize the HBP revision process? (Chapter 4)

Traditionally, analytical work to support HBP revision has placed strong emphasis on evidence collection – e.g., to demonstrate effectiveness and cost-effectiveness of services. However, there is a growing acknowledgement that HBP revision requires a rigorous and transparent, evidence-informed, deliberative process that makes full use of evidence on the one hand and is based on stakeholder deliberation to consider important societal values on the other hand. Such a process enables decision makers to justify a decision and what were the trade-offs, leads to decisions that are more likely to be seen as fair by stakeholders, and increases the buy-in for the HBP and the likelihood that it will be successfully implemented and funded. This guide proposes such a decision-making process for HBP revisions consisting of nine steps: making preparatory arrangements; installing an advisory committee; selecting services for evaluation and choosing a suitable approach to revision; defining decision criteria for prioritization of services; collecting evidence on decision criteria; prioritizing services; developing HBP as an implementable plan; establishing communication and appeal mechanisms; and ensuring monitoring and evaluation.

Which analytical approach fits best the local challenges? (Chapter 5)

Countries may face various challenges that require a revision of their HBP, such as concerns about the affordability or efficiency of the HBP; the automatic expansion of an implicit HBP that may be unsustainable; the pressure to include new services; the mismatch of the HBP with the burden of disease or (updated) health system goals; that the HBP is considered unacceptable by certain stakeholders; or that certain services are over- or underutilised. Each of these challenges might benefit from a tailored methodological approach. The guide helps countries articulate which approach (e.g., a whole package review, a partial review, incremental analysis, or a rapid review) they could consider for each challenge. In practice, countries may face more than one of these situations simultaneously, so they may need to combine the corresponding approaches.

Which data and evidence to use in HBP revision? (Chapter 6)

Data and evidence are essential to achieving a high quality HBP revision. For example, it is required in different steps of the HBP revision process to understand the performance of the present HBP, assess services in terms of the identified decision criteria including costing analysis, and estimate the necessary fiscal space. Budget impact analysis and accurate fiscal space projections are especially important and often neglected, as they contribute to the feasibility of HBPs and prevent unachievable aspirational packages being developed. Most countries will find the availability and use of data and evidence challenging; therefore, we encourage focusing efforts on developing sources of data and evidence that will grow in complexity over time.

How to engage in a successful policy dialogue? (Chapter 7)

The lack of common language, procedures, and systems, as well as differences in mandates and roles, can affect the ability of the Ministry of Health and Ministry of Finance to collaborate effectively. Fiscal space analyses can help ensure that HBP revisions are feasible and sustainable by ensuring that the revisions match the budget envelope for the HBP as a whole (which is a key concern to the Ministry of Finance). Further, embedding the planning of revisions within the budget cycle and tools employed by the Ministry of Finance for programming and managing of funds (e.g., risk registry, spending reviews, etc.) can foster collaboration between the two agencies.

The biggest challenge countries face is probably how to customise the HBP revision process, as specific circumstances can have a large impact on the HBP revision. There is no single right approach, so we encourage countries to learn from others that face similar challenges and have a comparable decision-making context, and to engage in networking. Networks such as the JLN, iDSI, RED CRITERIA, RedESTA, and HTAsiaLink provide that opportunity and form platforms for country collaboration on HBP revision and continuous learning.

Key Messages

1. Countries vary tremendously in the development, implementation, and revision of their HBPs, reflecting differences in socioeconomic and political context, maturity in their priority-setting processes, and expertise in HBP revision. Countries are encouraged to engage in networking for continuous exchange and to learn from other countries that face similar challenges and have a comparable decision-making context.
2. Many countries have developed packages that are challenging to implement in practice because i) services are not well-specified which may raise doubts over the precise entitlements people have, and/or ii) the package as a whole is aspirational which means it is not clear whether sufficient financial, human and material resources are available to provide all included health services at desired coverage levels.
3. Countries which experience such implicit packages upon implementation are advised to organise revisions to work toward an explicit HBP – a well-defined and affordable set of services that is clear on entitlements, facilitates implementation, and promotes equity.
4. An HBP is a living instrument that should be regularly revised. Revision requires institutionalizing a systematic, rigorous, transparent, and evidence-informed process with meaningful deliberation and stakeholder involvement. This will lead to decisions that are more likely to receive societal support and be implemented successfully.
5. During revisions, countries should always ensure sufficient resources to realize universal coverage of existing high-priority services before expanding the HBP with lower-priority new services. Countries are also advised not only to make decisions about the possible addition of new services to the HBP, but also to consider disinvestment – that is, removing low-value services to fund expanded coverage of higher-priority services.
6. Countries may have different reasons to revise their HBP, for example concerns about affordability or alignment with burden of disease. They are recommended to select and/or combine corresponding methodologic approaches – for example, a whole package or a rapid review – that suit these reasons.
7. Countries are advised to invest in accurate sources of essential data for HPB revisions. Costing, budget impact, and fiscal space analysis, for example, are essential to ensure that the services included in the revised HBP match the budget envelope for delivering the package.
8. Countries are advised to install institutional arrangements between the Ministry of Health and Ministry of Finance to foster collaboration, embed revisions in public finance frameworks and budget cycles, and tailor communication.

Chapter I: Introduction

Many countries around the world strive for universal health coverage (UHC) to provide the health services their populations need without causing financial hardship. A health benefits package (HBP) is a central policy instrument for countries to achieve this, as it defines the coverage of services, the proportion of the costs that are covered, and who can receive these services. Such HBPs can guide both the delivery of care and the associated resource allocation, including human resources, provider payment, procurement, and budgeting.^{11,27,28} HBPs essentially help countries make commitments to their populations in terms of the services that citizens can expect to be covered through pooled funding.

Once developed and implemented, an HBP cannot be static. It must be considered a living instrument that should be regularly revised to suit evolving health needs such as changing disease burdens, fluctuating budgets, and the emergence of new services and health technologies and to correct for implementation challenges. In this guide, we define HBP revision as the process of evaluating and updating the benefits package in terms of coverage of services, populations, and cost and in terms of its implementation mechanisms, through a review of either the whole package, a partial package, or individual services. Revisions ensure that the package is up-to-date and delivered as intended and that available resources are used to meet broader health system goals (e.g., efficiency, equity).

However, a recent review of HBPs in low- and middle-income countries (LMICs) shows that the majority of packages (14/24) have not been revised substantially – some despite having been in place for over a decade.²⁹ The Philippines, Colombia, and Chile are rare examples of countries that have built in legal provisions to review their HBPs on a periodic basis. However, most countries seem to initiate revisions in an ad hoc manner when a need is identified. An example is Armenia, which experienced a stark rise in the burden of chronic disease, exacerbated by a severe economic contraction due to the COVID-19 pandemic and a regional economic crisis disrupting a five-year period of rapid growth. Therefore, in 2021 Armenia's HBP needed to be thoroughly realigned to health needs and available fiscal space.³⁰ However, the reality is that most countries do not revise their HBP even when faced with significant changes in context and budgets, which can seriously impede the achievement of UHC.

While there are several guides to inform design of a new HBP, in particular through the lens of service prioritization,^{18, 27, 31–34} there appears to be a dearth of supportive resources on how to conduct revisions. To fill that gap, this Joint Learning Network (JLN) Knowledge Product aims to provide practical guidance to LMICs on the process and methods of HBP revision. It builds on work conducted during the first phase of the Efficiency Collaborative³⁵ and follows up on the interest in this topic expressed by member countries of the JLN Efficiency Collaborative (EC) in 2020. It was jointly produced with facilitators from Radboudumc and the Center for Global Development (as part of the International Decision Support Initiative – iDSI) and the World Bank, with input from country-level practitioners representing 14 countries from the JLN EC. The document has been informed by a review of the available literature but was predominantly developed based on country experiences from the EC members. Their responses and the examples they shared provide powerful insight into the real-world experience of implementing HBP revisions.

Country experiences were captured through a process of multiple engagements. First, we conducted a survey to capture country experiences with HBP implementation and revision, which was sent out in September 2021, targeting technical staff and decision makers involved in the management of HBPs in 14 LMICs in Africa (Ethiopia, Ghana, Kenya, Nigeria, South Africa, Sudan) and Asia (Bangladesh, India, Indonesia, Laos, Malaysia, Mongolia, Philippines, Vietnam). See Appendix A for the survey questions and Appendix B for the number of responses per country. Second, we held semi-structured interviews with technical staff and decision makers in 11 of the mentioned countries to follow up on survey responses and collect information on specific country experiences. Third, in August 2022, several EC members took part in a workshop in Delhi, India, which facilitated cross-country learnings and provided further insights into their HBP frameworks, how they use data and evidence, and how they

communicate and work with Ministries of Finance and Treasuries on financials of revisions. Fourth, EC members contributed additional content, based on their individual experiences, in the form of reports and official documents. Fifth, to complement the JLN experience, we added case studies from eight countries to reflect the experience of other geographies based on international literature review (e.g., Chile, which has a tradition of carrying out HBP revisions). See Appendix C for a summary of all country experiences that were considered. The content from the survey, interviews, workshop, and country experiences was then used to inform this guide. In addition, the facilitation team held regular online workshops to seek feedback from members on the content and outline of the knowledge product and provide progress updates. Members of the EC also used those meetings as a platform to share their experience with specific aspects of HBP revisions.

The guide is not meant to serve as a blueprint. We recognize that countries differ vastly in the social, economic, and political context that may affect their strategic choices in HBP revision. However, we document good practices that can be used or adapted accordingly.

We identify several limitations with regard to our approach and data sources. First, EC member countries may not be representative of the global experience with HBP revisions. Second, survey respondents and workshop participants were typically experienced technical staff with first hand experience and knowledge of the HBP in their country, and they consulted frequently with their respective country colleagues/collaborators. However, their responses are not necessarily representative for the country. Third, while the scope of HBP revision is defined broadly, the guidance focuses most specifically on changes in service coverage. Other aspects of revisions that are similarly important such as changes in population or cost coverage, or in HBP implementation mechanism such as provider payment arrangements, are covered more superficially. This reflects a bias of the literature toward prioritization as well as the professional experience of EC members and facilitators. We hope that future resources will complement this guide to address those points in more depth.

The guide is organised according to the following six broad questions that are addressed in the subsequent chapters: what are EC members countries' experiences with HBP revision? (Chapter 2); what is important in HBP revision? (Chapter 3); how to practically organize HBP revision? (Chapter 4); which analytical approach fits best the local context? (Chapter 5); which data and evidence to use in HBP revision? (Chapter 6); and how to engage in a successful policy dialogue? (Chapter 7). We illustrate the chapters with several "country spotlights" that describe the experience of countries on specific topics.

Chapter 2: EC members' experiences with HBP revision

EC members collectively represent a broad mix of experiences from across 14 countries in Africa and Asia (Table 2.1 provides their characteristics). EC members were mostly middle-income countries (12/14), with the exception of Ethiopia and Sudan (South Africa and Malaysia are upper middle income). Current health expenditure per capita averaged US\$147 across the sample.

Table 2.1. Country characteristics of EC members 2019

	Country	Income group	Current health expenditure per capita (US\$)	Domestic general gov health expenditure per capita (US\$)	Domestic general gov health expenditure (% current health expenditure)
1	Bangladesh	Lower middle	45.86	8.54	18.63
2	Ethiopia	Low	26.74	6.07	22.70
3	Ghana	Lower middle	75.28	30.29	40.24
4	India	Lower middle	63.75	20.90	32.79
5	Indonesia	Lower middle	120.12	58.79	48.94
6	Kenya	Lower middle	83.41	38.35	45.98
7	Laos	Lower middle	68.22	25.20	36.93
8	Malaysia	Upper middle	436.61	227.90	52.20
9	Mongolia	Lower middle	163.44	92.59	56.65
10	Nigeria	Lower middle	71.47	11.40	15.95
11	Philippines	Lower middle	142.08	57.68	40.60
12	South Africa	Upper middle	546.69	321.23	58.76
13	Sudan	Low	46.93	10.65	22.69
14	Vietnam	Lower middle	180.72	79.15	43.80

Source: <https://data.worldbank.org/indicator>.

Our survey among EC member countries, as described in Chapter 1, shows that almost all countries have an HBP.^b However, it also revealed a wide breadth of experiences in HBP development, implementation, and revision. Sudan and the Philippines were the first of our sample to develop an HBP, in 1994 and 1995 respectively. The first revision was recorded in the Philippines almost two decades after the first definition of the HBP (Figure 2.1). Interestingly, one country noted that they had initiated a revision but that it failed in the process because of inability to manage stakeholder dissatisfaction and pressures.

Respondents reported that revisions were often initiated because of a perceived political need rather than on a periodic basis. Five countries noted that the requirement for revisions was written in law or regulation in the country.

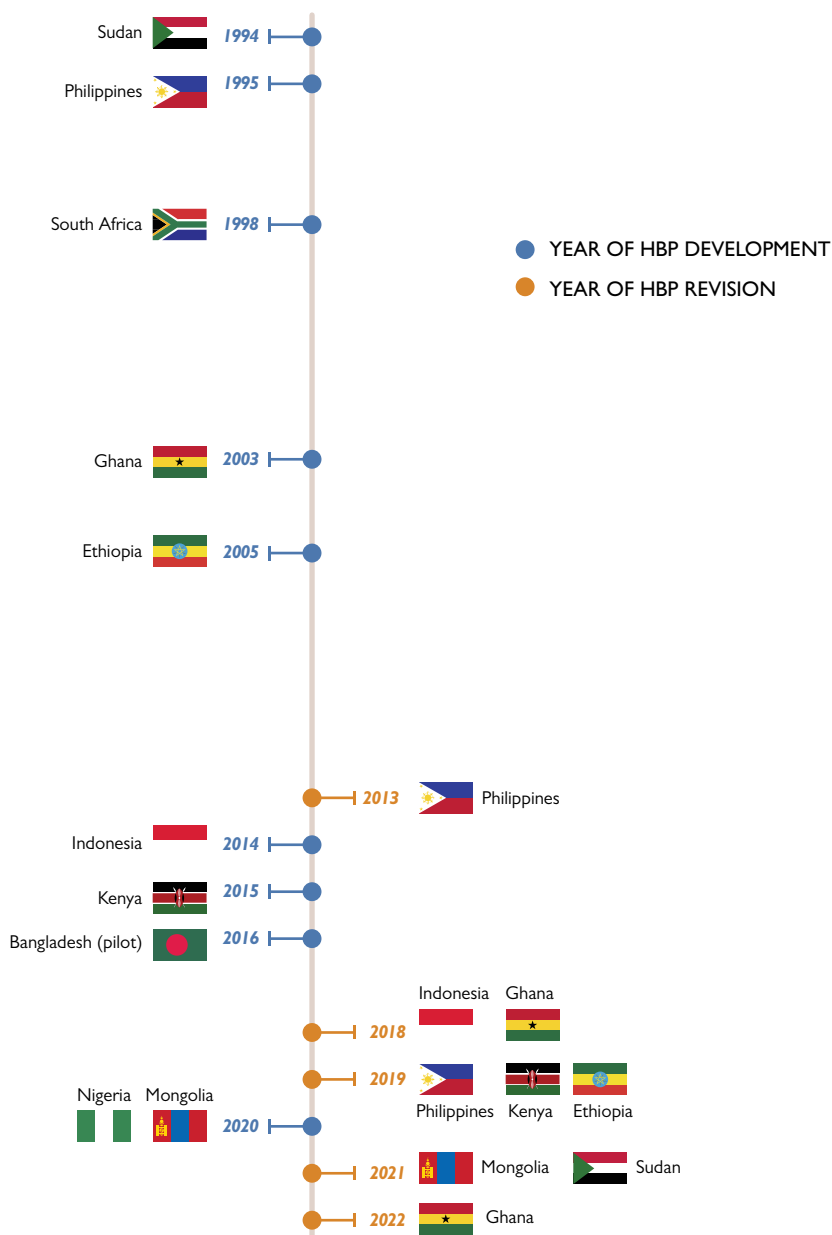
^b In the survey, we asked respondents to only consider “implemented HBPs,” which we define as having at least i) a funding pool to support its delivery, or ii) funding lines to reimburse providers for the provision of services, or iii) entitlements enshrined in law. This allowed us to differentiate between implemented HBPs and more aspirational packages of care, which most LMICs will have developed in the last two decades.

However, of those five countries, two mentioned that no time frame was mentioned in the law and, as a result, revisions were not regularly undertaken. In addition, one country mentioned an annual revision requirement, but only to ensure that the tariffs used for provider payment were regularly updated; as a result, entitlements were not reviewed annually.

The main reasons for HBP revision include insufficient financial, human, and infrastructural resources to deliver the package. Other reasons given for updating the package included “the package is out of date” and “too many high-cost services in the HBP” (Figure 2.2).

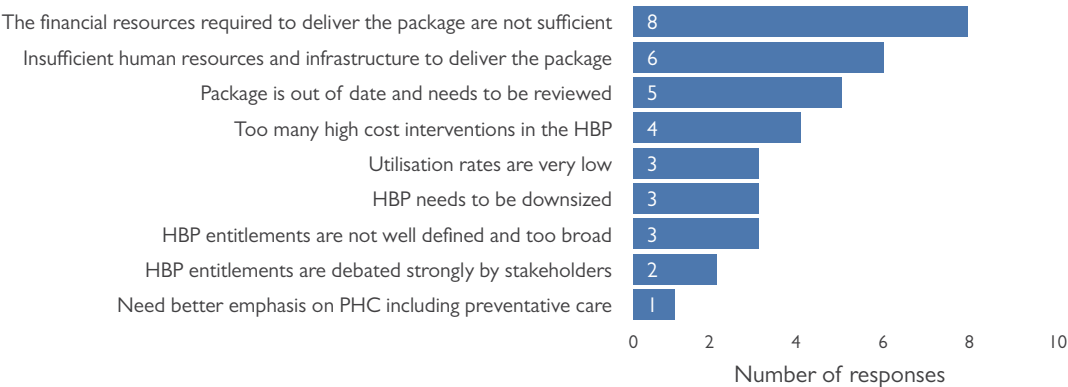
In line with our definition of revisions, many respondents highlighted the scope of revisions included: delisting and adding services, rate setting and updating (for the payment of providers), re-budgeting, changes in organisation of the package (e.g., nomenclatures) or changes in the population coverage (e.g., adding affiliates).

Figure 2.1: Timing of initial HBP design and revisions per country



Source: JLN EC members survey, 2022

Figure 2.2: Reasons for HBP revision expressed by countries



Source: JLN EC members survey.
 Note: Included countries are Bangladesh, Ghana, Indonesia, Kenya, Mongolia, Nigeria, Philippines, and Sudan. Each respondent was asked to select three reasons. Some countries had more than one respondent. If a specific reason was selected by multiple respondents from the same country, it was counted as one.

The length of the process varied widely between countries. At one extreme, a country reported that the revision took one month and was conducted solely by the health financing team at the Ministry, with no engagement with external stakeholders. It is worth noting that this country mentioned that the revision was disputed and had to be revised months later. Three countries mentioned one and a half to two years as a timeline. At the other extreme, the revision in Bangladesh took four years to complete because of the scope of the review (entire package and review of all health needs in the country), the lengthy process for engagement, the process for securing the appropriate budget, and learning from implementation on the ground (through piloting of the revised package and refining the revisions) (see Bangladesh Spotlight).

Bangladesh Spotlight
Defining the HBP for Shasthyo Surokhsha Karmasuchi (SSK)

SSK started as a pilot programme in 2016 with the aim to reduce out-of-pocket expenditure and catastrophic health expenditure for the country’s vulnerable population living below the poverty line. The first version of the SSK HBP was developed by a panel of clinical experts as a realistic and implementable package to provide healthcare in primary and secondary public facilities. Since the piloting, extensive feedback and consultations with stakeholders (e.g., service providers, affiliates) were carried out, resulting in considerable expansion of benefits from 50 conditions to 78, and a further increase to 110 awaiting approval at the time of writing. This led to the inclusion of many surgical interventions such as cataract surgery. This decision to expand was made after consideration of health needs and fiscal space.

In addition, the affiliates of the scheme has also increased significantly. Potential beneficiaries identified through multi criteria questionnaires targeting vulnerability (including poverty). Eligibility is determined by a cutoff point in the scoring of the questionnaire, which is expanded, again, based on available fiscal space and/or increasing demands.

All countries reported engagement with the following categories of stakeholders: different departments within the Ministry of Health, academia, health providers, development partners, insurance funds, subnational governments, and Ministries of Finance. In one country, an independent panel with wide representation of stakeholders (including civil society in addition to the above stakeholders) was established and working with Ministry oversight.

Countries shared positive and negative lessons in the survey, which we consolidate into principles and report on in Chapter 3. One lesson was the need to define a clear framework for revisions; some of the benefits of having a clear framework included

- improving overall quality of the revision decisions,
- improving buy-in,
- avoiding biases and influence from certain stakeholders,
- providing clarity for patients, and
- improving data collection and IT systems.

In addition, one country highlighted that, without a strong framework, the initial problems in HBP design would re-emerge, with a replication of deficiencies in subsequent revisions.

Take-away messages

1. Revisions are scarce, even in countries where revisions are mandated by law. Few countries have processes and structures in place to periodically review their HBPs.
2. EC members developed and revised their HBPs at different times, but all found challenges upon implementation.
3. Revisions can be as short as less than four months or as long as four years depending on the scope and the process followed.
4. Challenges were often linked to insufficient consideration of financial, human, and infrastructural constraints.

Chapter 3: What is important in HBP revision?

Based on EC members countries' experiences, interviews, and literature review, we define five important principles that can inform countries' HBP revision. These principles are described in detail below and are congruent with the principles of HBP design as proposed by WHO.³⁶

Table 3.1: Five Principles of HBP Revision



Principle 1: HBP revisions should be seen as an evolutionary process

Many countries designed their first benefits packages over the last few decades, following the World Bank's 1993 World Development Report that called for an explicit, minimum package of services based on cost-effectiveness to reduce the overall burden of disease.³⁷ However, the initial packages were often implicit, meaning they were difficult to implement in practice because i) services were not well-specified which raised doubts over the precise entitlements people have, and/or ii) the package was aspirational which means it was not clear whether sufficient financial, human and material resources were available to provide all included health services at desired coverage levels. Such implicit packages may lead to inequities since some population groups, such as urban residents, may end up receiving nearly the full package, taking away resources from others, such as rural residents in remote areas.³⁸

Countries are advised to move toward explicit HBPs, that is, a well-defined and affordable set of health services that is available to a population. Well-defined means that it is clear who is entitled to what kind of services. Affordable means that sufficient financial, human, and material resources are available to provide all included health services at desired coverage levels. Although it is often politically harder, explicit packages ensure the actual delivery of the promised package and allow for greater control of the HBP.³⁸ The use of a negative or positive lists allow countries to make explicit guarantees to citizens, which is important given the budget constraints and risks of overspending. The report "Going universal" shows that most countries are moving toward an explicit package with a positive list, although some countries prefer to use a negative list.³⁸ In reality, countries may also use combinations of positive and negative lists – for instance, a positive list for covered services and a negative list for services that were evaluated and where the decision was to not cover them. To illustrate, the EPHS in Ethiopia underwent a revision recently by moving from an implicit package towards an explicit package with a positive list. The HBP in Malaysia

is an example of a partly implicit package: there is a positive list of medicines and procedures that are covered, but there is no such list for devices.

This evolution requires the development of a more mature HBP design process in terms of – for example – political support, institutional arrangements, legal framework, stakeholder participation, and technical skills.³⁹

Principle 2: Aim for universal coverage of existing priority services before expanding the package

In many countries, governments have the tendency to expand their explicit HBP with additional services following pressures from health professionals, manufacturers, patient organisations, and/or other interest groups. However, in the context of restricted healthcare budgets, the introduction of such services may very well induce a reduction of spending on existing high-value services and create shortages of personnel and/or materials, and ultimately affect the quality of care, create waiting lists, or even lead to services not being available. This phenomenon is referred to as ‘crowding out’ or sometimes ‘displacement’. Crowding out is harmful to a health system when the value of the newly introduced services is lower (i.e., produce less health benefits) than that of the existing services. An example would be to expand coverage for coronary bypass surgery before securing universal coverage for skilled birth attendance. Crowding out is also problematic because, unlike disinvesting in low value services (see principle 3), it is not a deliberate decision and it is not clear what funding is displaced for which service.

We advise countries to ensure available resources are put toward achieving universal coverage of high-value (i.e., high-priority) services within the package, before considering revisions to expand the HBP with lower-value services.

Principle 3: Disinvest from low-value services

Countries are advised to not only make decisions about the possible addition of new services to the HBP, but to also think about disinvestment – that is, removing low-value services from the package. The reason is that the inclusion of such low-value services in the HBP takes resources away from the (further) implementation of high-priority services. However, disinvestments are notoriously difficult to achieve because it is not always clear what the low-value services are, and careful analysis is needed (see Chapter 5 for more detail). Moreover, governments often experience stakeholder pressures from, for example, health professionals or patient interest groups, to retain services that they are used to. In practice, proposed disinvestments have a greater chance to succeed if they do not involve an absolute exclusion. Realistic alternatives can be to introduce co-payment (or increase the level of co-payment), or to make coverage conditional on certain patient indication criteria. Because of these challenges, we recommend countries to carefully select which services to disinvest from – if services use and/or costs are low, it may not be worth the effort.

The challenges that disinvestment poses are illustrated in our survey, in which most of the respondents indicated that their countries had added services to the package during the revision process but had not removed any. Only Indonesia and Nigeria reported to have taken out services from their HBP. The Vietnam spotlight shows that disinvestment decision can lead to large savings – removal of inappropriate indications was estimated to save the country annually around US\$150 million.

Vietnam Spotlight*: Rapid review of (cost-)ineffective interventions

Vietnam started national Social Health Insurance in 2008, which is managed by the Vietnam Social Security agency (VSS). The key concern regarding the current benefits package is that, while it specifies the medicines and services that qualify for reimbursement, it does not specify the indications for which these interventions are considered appropriate. More than 17,000 medical services, 9,000 medicines, and a long list of medical supplies are included in the package, leaving room for overutilization, including potentially ineffective or harmful use, and implying an immense financial burden.

To inform a thorough revision of the benefits package, a rapid review was conducted based on the top 40 interventions in terms of VSS's budget spending. International evidence on the safety, clinical efficacy, and cost-effectiveness of these interventions was triangulated with input from Vietnamese clinical experts. This yielded recommendations for stricter medical indications.

The review found that only 22 percent of expenditure for medications reimbursed through VSS was for appropriate indications; 27 percent of expenditure had some clinical benefit but was labelled as "poor value for money"; the remaining 51 percent of medication expenditure was for inappropriate indications. This demonstrates a significant negative impact both in terms of clinical efficacy and budget impact of an overly generous reimbursement policy. It was estimated that the removal of inappropriate indications would save VSS about VND 3,300 billion annually (roughly US\$150 million), and an additional VND 1,700 billion (US\$80 million) if medications for indications with limited or unproven value for money were eliminated. In total this represented approximately 70 percent of the annual VSS budget.

These findings indicate a huge opportunity for the Vietnamese government to revise the health benefits package for more rational use of medication at a lower cost, without negatively affecting health outcomes.⁴⁰

* Information not verified by country.

Principle 4: Ensure the revisions to the package are costed, within budget, and appropriately resourced

Our survey highlighted that the main obstacle to HBP implementation and driver to initiate revision is the insufficient resourcing of the HBP as a whole. This creates a situation whereby providers are forced to implicitly ration some services (because they are not sufficiently paid and equipped to deliver the services), and/or quality may be compromised; in other words, the HBP delivery is no longer aligned with its strategic goals. Unfortunately, it is not uncommon for countries to revise their HBP without any changes to the budget or provider payment method.

We advise countries to consider the financial implications of revisions: not only to cost and adequately budget the proposed revisions and the overall new revised HBP, but also, where relevant, to adjust prices or tariffs used to pay providers to reflect an increase or decrease in coverage of services from the HBP.

Principle 5: Institutionalize periodic revisions to help stay on the path to UHC

Several countries have so far reviewed their initial benefit package just once or twice, sometimes over the course of several decades. Very few have a built-in revision process to their UHC scheme. Chile developed provisions for periodic revisions (every three years), which have been written in law. India's national public health insurance scheme AB-PMJAY has so far undergone three revisions since its launch in September 2018. The iterations have mostly focused on revising the structure and nomenclature used in the HBP, as well as updating the reimbursement rates for various procedures, based on health service utilization rates, new data from costing studies, and the latest inflation rates.

Establishing a mechanism to revise the HBP on a periodic basis not only helps to ensure that the HBP responds to the UHC strategy and is implemented adequately, but also helps the planning and strengthening of evidence and data collection, making revision decisions more transparent and accountable, and helps to channel effectively the inputs of different stakeholders.

Take-away messages

We identify five principles to HBP revision:

1. HBP revisions should be an evolutionary process
2. Aim for universal coverage of existing priority services before expanding the package
3. Disinvest from low-value services
4. Ensure the revisions to the package are costed, within budget, and appropriately resourced
5. Institutionalize periodic revisions to help stay on the path to UHC.

Chapter 4: How to organize the HBP revision process?

Traditionally, analytical work to support HBP revision has placed strong emphasis on evidence collection to demonstrate effectiveness and cost-effectiveness of services.¹¹ However, there is a growing acknowledgement that HBP revision requires several other activities and a systematic approach, and that the entire process should be fair.^{31, 41} Fairness in HBP revision can be promoted by ensuring transparency of the revision process and by organising meaningful stakeholder involvement.^{41, 42}

We derive nine steps to an HBP revision process from engagement with the EC members, drawing heavily on key guides for HBP design and revision including the WHO report “Institutionalizing HTA,” which proposes the use of the evidence-informed deliberative processes framework (EDP)^{42, 43}, the book “What’s in, what’s out: designing benefits for universal health coverage”^{18, 27, 32} (see Figure 4.1), and a recent review of HBP revision processes in six LMICs.⁴⁴ The stepwise process is not meant to serve as a blueprint – countries can change the order and contents of the various steps depending on their local decision-making context.

In the process, various steps only need to be developed once and can remain unaltered throughout several revision cycles, such as installing an advisory committee (step 2), defining decision criteria (step 3), and establishing communication and appeal mechanisms (step 8). Other steps, such as collecting evidence on decision criteria (step 5) and prioritizing services (step 6), need to be done for every service, in every revision cycle. Remaining steps (1, 3, and 9) involve some activities that can remain unaltered throughout revision cycles and other activities that are specific to one revision cycle.

This chapter provides a brief overview of all the steps, whereas next chapters focus on steps that the EC members requested support on: selection of services for evaluation and approach to revision (step 3, in Chapter 5) and collection of evidence on decision criteria for services, including costing and budgeting (step 5, in Chapter 6). The interested reader can find further details on other steps elsewhere.³⁴

Figure 4.1: The stepwise HBP design and revision process

1. Make preparatory arrangements
2. Install an advisory committee
3. Select services for evaluation and choose a suitable approach to revision (chapter 5 for details)
4. Define decision criteria for prioritization of services
5. Collect evidence on decision criteria (chapter 6 for details)
6. Prioritize services
7. Develop HBP as an implementable plan
8. Establish communication and appeal mechanisms
9. Ensure monitoring and evaluation

Step 1: Make preparatory arrangements

The successful revision of an HBP requires an adequate match with the decision-making context. We advise countries to undertake preparatory arrangements, in order to:

- review the existing HBP and its scope in terms of diseases, levels of care, and utilization patterns;
- define the objectives of the HBP revision;
- estimate approximate budget for services covered by the HBP;
- assess the institutional design, that is, the legal and regulatory context of the HBP revision;
- identify all stakeholders involved in HBP revisions and their roles;
- assess the technical capacity to undertake the revision, and plan and commission any research that may be required to support the revision;
- define a roadmap to articulate the steps of the revision process;
- assess and secure the necessary financial resources for the work involved, such as data and information gathering, analysis, and committee meetings.

Step 2: Install an advisory committee

We advise countries to install an advisory committee, that is, a central decision-making committee that prepares recommendations for HBP revisions for consideration by the final decision maker, typically the Minister of Health.⁴⁵ This advisory committee should reflect a broad interest in spending public money wisely, and this means that its composition should mirror the diversity of societal values present in the general population. The committee (or a subcommittee) will also need to have members with the appropriate technical skills to provide a detailed appraisal of the analysis.

Countries have taken different approaches in realising this, and their advisory committees often include two types of formal members. The first type includes members for their professional or scientific expertise, such as clinicians, public health experts, ethicists, economists, and epidemiologists. The second type includes members based on the interests they represent, such as patient and carer organisations or industries. Note that these latter members represent the general interests of patients and industry and not specific interests regarding particular services. Governments normally decide which members have voting power in an advisory committee. More details on installing an advisory committee can be found elsewhere.³⁴

Where necessary, the advisory committee can be supported by sub-advisory committees that develop preparatory recommendations on specific disease programs. Countries may also wish to install technical task forces that can provide additional assistance to the advisory committee – for example, in evidence collection.

Advisory committees may also find it useful to involve stakeholders with a direct interest in the service(s) under scrutiny. Possible conflicts of interest should be identified when inviting stakeholders, and the modality of their engagement should be tailored to those. There are different ways of doing that: (i) stakeholders can be allowed to take part in deliberations during formal meetings but without any voting rights; (ii) alternatively, they can be consulted during formal meetings (in non-deliberative ways) where they have the opportunity to provide verbal comments; (iii) another option is stakeholder communication in which stakeholders are simply informed about the revision processes and/or the recommendations that are eventually made (or the decisions that are taken).⁴⁶ For example, it can be useful to involve patient representatives in advisory committee meetings as they can identify relevant treatment outcomes for consideration in the evaluation. Likewise, industry representatives can provide background information on price structures and/or upcoming innovations. Note that extensive stakeholder involvement may also have disadvantages – it may be time intensive and delay decision making and may also be costly in terms of practical arrangements. While stakeholder involvement can generally be considered an essential element of HBP revision, countries should also consider these disadvantages when designing how extensive this engagement process should be.

To illustrate, the HBP revision process in Ethiopia and Pakistan involved 80 and 183 participants respectively, representing different stakeholder groups, mainly health professionals and policy makers. The Pakistan spotlight A provides more details. In Zanzibar, a semiautonomous region that is part of the United Republic of Tanzania, 225 stakeholder representatives were involved, including a large number of patients and community members.⁴⁴ In all three countries, stakeholders were involved through direct participation.

Pakistan spotlight A: Stakeholder involvement

The 2019–20 revision of the UHC benefit package in Pakistan employed a governance structure based on three connected stages of deliberation around several specific priorities and involved more than 100 stakeholders.

The first stage concerned the involvement of four Technical Working Groups (TWGs) for specific disease clusters: Reproductive Maternal Neonatal Child and Adolescent Health (36 members), Noncommunicable Diseases (NCDs) (38 members), Communicable Diseases (51 members), and Health Services Access (26 members). These TWGs with experts from different interest groups had already been in place to advise the Ministry of Health. They were now tasked with reviewing the technical aspects of services and interventions for their potential inclusion in the standard service package and with broadly allocating them to priority categories, with each TWG covering between 28 and 51 services. The second stage involved the installation of a National Advisory Committee (NAC) with the mandate to review and consolidate the four sets of TWG recommendations. The NAC had 90 members, including members from various societal interest groups, development partners, and provincial representatives, plus just one representative from each of the TWGs to avoid domination by any disease- or discipline-specific interest group. In the third stage, a high-level Steering Committee (SC) was tasked to review the NAC recommendations and turn them into policy proposals.

The TWG, NAC, and SC meetings were organised so that each member had an equal chance to contribute to the deliberations; TWG members were granted voting power.

Step 3: Select services for evaluation and choose a suitable approach to HBP revision

Countries often have limited capacity to undertake HBP revisions, hence choices need to be made as to which services will and which will not be evaluated. Ethiopia and Pakistan have undertaken whole benefits package reviews, whereas Iran targets certain service clusters for HBP revisions. Chapter 5 provides practical guidance on how countries can choose the most suitable analytical approach for their specific decision-making context.

Step 4: Define decision criteria for prioritization of services

Revising an HBP should ideally be based on a limited number of broadly endorsed, explicit criteria. A recent review across 23 countries shows that countries employ a range of decision criteria when defining or revising their HBP, with cost-effectiveness, effectiveness, and budget impact most frequently used (Table 4.1).⁴⁷ These reflect the widely recognized goal of maximizing population health by the use of services that are proven to be both effective and cost-effective. In the context of UHC, the WHO “Making Fair Choices” report proposes to also use one or more equity criteria, such as priority to the worse-off and financial risk protection.³¹ The worse-off can be defined as those with least health without the service, or the poorest population groups, or disadvantaged people.

We advise countries to identify criteria that are relevant to their own specific context. They can do this by first specifying key values of their health system or by using criteria defined for the initial HBP development – for example, maximizing health, taking care of disadvantaged people, and so forth, through review of national health strategies and/or stakeholder consultation. Second, they need to operationalize decision criteria that reflect these values. For example, the value “maximising health” can be operationalized in the decision criterion “cost-effectiveness.” Consensus building among stakeholders is essential in this process.⁴⁸ More details on decision criteria can be found elsewhere.^{34, 47}

By way of example, the Health Intervention and Technology Assessment Programme (HITAP) in Thailand appraises services by their cost-effectiveness and budget impact. The Philippines uses severity of disease, effectiveness of the service, cost-effectiveness, and household financial impact as criteria for their HBP.⁴³ Ethiopia revised its Essential Health Service Package (EHSP) in 2019 based on seven criteria: disease burden, cost-effectiveness, equity, financial risk protection, budget impact, public acceptability, and political acceptability.⁴⁹ The Ethiopia spotlight A provides more details.

Table 4.1: Criteria for HBP design and/or revision

Category	Criteria	Frequency
Service-related criteria	Cost-effective	20
	Effective	19
	Budget impact	12
	Necessity	10
	Safety	6
	Sustainability	5
	Feasibility	5
	Costs of service	4
	Comprehensive	3
	Maximizing the improvement of population health status	3
	Scaling up	1
Disease-related criteria	Innovation	1
	Burden of disease	10
	Externalities	2
	Severity of disease	1
Community-related criteria	Equity	12
	Affordability	5
	Social values	4
	Access	2

* Frequency refers to how many countries, of the 23 countries included in the review, use a certain criterion in their HBP design and/or revision.

Ethiopia spotlight A: Whole package review

Ethiopia revised its essential health services package (EHSP) in 2019. A total of 35 consultative workshops were convened with experts and members of the general public to define the scope of the revision, select health interventions for review, agree on the prioritization criteria, gather evidence on the performance of the selected interventions on the agreed criteria, and compare health interventions. Seven prioritization criteria were chosen: high disease burden, cost-effectiveness, equity, financial risk protection, budget impact, public acceptability, and political acceptability.

In the first phase, 1,749 services were identified, including existing interventions and new ones, which after regrouping resulted in 1,442 interventions that were deemed relevant. The second phase involved the removal of interventions that did not match the high burden of disease criterion or were deemed not relevant in the Ethiopian setting, reducing the number of eligible interventions further to 1,018. These were then evaluated based on the six other criteria and subsequently ranked. Eventually 594 services were classified as high-priority (58 percent), 213 as medium-priority (21 percent), and 211 as low-priority interventions (21 percent). The current policy is that 570 services (56 percent) are provided free of charge; for the remainder, cost-sharing (38 percent) or full cost-recovery (6 percent) is being applied.

The revision of Ethiopia's EHSP followed a participatory, inclusive, and evidence-based prioritization process. The interventions included in the revised EHSP were comprehensive and assigned to health care delivery platforms, each with a specific financing mechanism.⁴⁹

Step 5: Collect evidence on service performance on each of the selected decision criteria

The initial development and subsequent revisions of an HBP should ideally be based on up-to-date local evidence on how services perform on the agreed decision criteria. Such assessments involve a range of activities for each of the selected services: systematic evidence collection; synthesizing the available evidence, taking into account the quality (strength) of the evidence; independent review of the evidence; and reporting findings and implications. Chapter 6 provides detailed methodological guidance to undertake assessments, including the need to do adequate costing analysis to determine the resources needed for the package. The Pakistan spotlight B illustrates how technical working groups used evidence summary sheets in their deliberations.

Pakistan spotlight B: Compilation of evidence summary sheets for use by advisory committees

The Technical Working Groups tasked to justify inclusion of specific services into Pakistan’s UHC benefit package – or, alternatively, to recommend their exclusion – were provided with “half pagers” that summarised the available evidence on all relevant criteria in a uniform manner: one half pager / summary sheet per service. The standard criteria that had been agreed upon earlier were: cost-effectiveness, avoidable burden of disease, budget impact, feasibility, equity, financial risk protection, and socioeconomic impact.

In view of the large number of services that needed to be evaluated and to avoid cognitive overload, the evidence was presented in the form of colour codes (green/amber/red) and symbols (one, two, or three stars) – see the example below. Cost-effectiveness ratios, for example, were categorised with reference to thresholds: interventions were labelled green if they were found very cost-effective, amber if moderately cost-effective, and red if not cost-effective. Applicability of the evidence to the context of Pakistan was indicated with one, two, or three stars, reflecting low, medium or high applicability, respectively.

Evidence summary

Intervention HC38: Provision of aspirin for all cases of suspected acute myocardial infarction

Cost-effectiveness	Cost-effectiveness rank order	Quality of ICER	Potential DALYS averted
Medium	31 / 86	★★★	Low
Budget impact	Cost per capita	Secondary / tertiary care budget impact	Also Consider: Feasibility; Financial risk protection; Equity; Social and economic impact
Low	0.66 PKR	No	

The summary sheets, along with the full evaluation results in a background report, were made available to the National Advisory Committee for their appraisal.

Step 6: Prioritize services

In the prioritization of services, the advisory committee interprets the results of the assessment in a broader perspective – it judges the importance of the different decision criteria, considers the available budget (ensuring the revisions are still within the financial envelope), and formulates recommendations on investment or disinvestments for the final decision makers. An important challenge is how an advisory committee can best trade off decision criteria. For example, should they recommend the inclusion of palliative care services in the HBP, even though it may not be cost-effective because it targets the worst-off? This is an intrinsically complex and value-laden task and requires social and scientific judgements. Another challenge is that evidence and data may be incomplete, outdated, or not available, which would require making informed judgements. We recommend countries to use a deliberative process to do this, which allows committee members to express and discuss their preferences and considerations and bring in their knowledge and judgement when complete data are unavailable. A deliberative process also increases people’s understanding and support for the eventual outcome.

Such a process is not devoid of challenges: it is resource intensive (e.g., typically takes time) and may be biased based on the composition and working methods of the committee. There are specific approaches available to reduce stakeholder dominance, such as the nominal group technique.⁵⁰ This approach starts by asking all committee members individually to express their preferences and considerations. In a subsequent group phase, all individual contributions are listed on a chart and discussed in the order they appear. The chairperson invites all members to comment, ask questions for clarification, and express their agreement or disagreement. Subsequently, all members are asked to make their judgement independently. An additional round of discussion may follow in which the judgements and the reasons behind them are discussed. More detail on the prioritization of services can be found elsewhere.^{34, 51}

Note that steps 5 and 6 can be iterative, as the advisory committee may conclude that more evidence or more contextualised evidence is required to review the service priorities.

Step 7: Develop HBP as an implementable plan

Once services are prioritized, the planning of implementation of the package needs to occur to ensure that services are provided or accessible to eligible citizens. As highlighted in the survey, many countries face challenges in implementation. These include not only financial constraints but also broader health systems issues, such as shortages of human resources, substandard infrastructure, and fragmentation of service delivery across different levels of the referral chain. When revising their HBPs, Ethiopia, Pakistan, Somalia, and Zanzibar established an implementation plan, by considering the various service delivery platforms, existing health systems enablers and barriers, and required investments.

We therefore advise countries to develop an implementation plan, which should include the following considerations:

- Budgeting and resourcing at the Ministry of Finance/Treasury level to match the extent of the services provided
- Working with purchasers of services (e.g., state or district government authorities, procurement agencies) to plan for implementation of the revisions
- Revision of a related drug, diagnostic, and device procurement list
- Planning of healthcare resources (including human resources) to meet the expected increase in demand
- Revision of provider payment methods, including tariffs for hospitals or pricing for other types of providers
- Alignment with and implementation of standard treatment guidelines (STGs)

The Ghana spotlight A illustrates how the country uses STGs to implement its benefit package. The Ministry of Health in Kenya uses a strategic procurement framework for that purpose, as shown in the Kenya spotlight.

Ghana spotlight A: Standard treatment guidelines and reimbursement decisions

Ghana started implementing its National Health Insurance Scheme (NHIS) in 2004 with the aim of achieving universal health coverage. In 2021, the scheme covered 54.4 percent of Ghana’s population. The NHIS reimburses credentialed providers for services provided to its registered members based on treatment protocols outlined in Ghana’s Standard Treatment Guidelines (STG). The STG are authored by the Ministry of Health and reviewed periodically by clinical experts based on the latest clinical evidence. Medicines recommended for treating ailments in the STG are included in Ghana’s Essential Medicines List (EML). The National Health Insurance Authority (NHIA) follows the STG and EML for the inclusion of medicines in the NHIS Medicine List (NHISML). It reimburses health providers based on the levels of prescribing policy to restrict the undue use of medications. This, aside from ensuring the safe use of medications at appropriate healthcare levels, also saves on cost from possible inappropriate or unlimited use of medications.

This streamlined process offers a standard approach to reimbursement for all healthcare facilities and enables the NHIA to focus on its role of financier while the MOH prescribes the recommended treatment pathways and defines where care for ailments can be sought. Ultimately, this approach standardizes treatment and reimbursement, and it eliminates contention and vetting decisions. With the institutionalization of health technology assessment (HTA) in Ghana, it is expected that all treatment protocols and medications in the STG and EML will be subjected to cost-effectiveness analysis to further promote evidence-informed reimbursement decisions.

Kenya spotlight: Strategic procurement of health services

For the revision of the National Health Insurance Fund (NHIF), the Ministry of Health in Kenya uses a strategic procurement framework that was developed on the basis of various country-level review reports and the NHIF strategic plan.^{6,7} The framework has four pillars:

Essential Health Benefits	Procurement / Contracting	Benefits Financing	Monitoring and Clinical Quality
<ul style="list-style-type: none"> A 12-point criterion for prioritization of what to finance; responds to the tenets of equity, access, financial risk protection, population needs, and GOK health sector priorities Scope of benefits, reimbursement, payment method, co-payment, and eligibility are explicit and shift to financing the treatment plan as per national guidelines Developed in line with MOH recommendations and global best practice, and shared with stakeholders 	<ul style="list-style-type: none"> All licensed and registered providers as per sec30 of the NHIF Act Explicit contracts defining responsibility, liability, and reimbursements Standardized terms of engagement, reimbursement, and product mix to reduce fragmentation and inequity and to distribute risk Expand primary healthcare utilization using financing incentivization Shift to selective procurement for specialized procedures 	<ul style="list-style-type: none"> Projected revenue sources and estimated amounts have been profiled Provider payment mechanism (PPM) and liability for each of the benefits contracted has been defined The risks, projected utilization per benefit, cost projections made Adopts risk-adjusted financing; considering disease patterns, age and age category, location and catchment, etc. Biennial costing studies and national stakeholder forums planned 	<ul style="list-style-type: none"> Service need criteria to identify underserved areas of the country Shift to outcomes-based financing (clinical outcomes); 37 quality indicators in the performance dashboard Integrate electronic medical records and artificial intelligence Actuarial analytics for product assessment, prospective analytics, and risk management Targeted surveillance and medical audits

Step 8: Establish communication and appeal mechanisms

Communication and appeal are important procedures that enhance the legitimacy of HBP revisions by disseminating all changes made in the initial package, including the underlying argumentation. Countries should strive to ensure that reimbursement decisions (and changes therein) are communicated through a variety of channels to all relevant stakeholders, including the general public.

An appeal mechanism refers to a channel and procedure through which stakeholders have the possibility to apply for a reversal of a decision, or a reassessment of a recommendation, based on new arguments or new evidence that may have become available. Countries should establish an appeals procedure, including the requirements regarding provision of new evidence and clear revision rules.⁴¹

Step 9: Ensure monitoring and evaluation

Monitoring and evaluation (M&E) involves a process of systematically collecting data over time on a set of predefined indicators and using these data to judge if objectives and expectations are being met and if corrective measures are required. Ideally it should be designed upfront, based on the situational analysis and as part of step 1, and then refined once all other steps are taken.

The M&E may reveal how the revised HBP is being implemented and/or its overall impact, and enables these agencies to be responsive to new insights and correct for potential shortcomings in a timely and proactive manner by implementing measures for improvement.^{52,53} For instance, utilization and cost data (for services included in the revised HBP) may be routinely or periodically collected to ensure that demand and access for services change as a result of the implementation of the revised HBP. This can be done at low cost if health information systems are in place and aligned with the provision of the HBP. As we discuss in Chapter 7, financial information (e.g., expenditure data) should be collected and reviewed at least biannually to enable decision makers to take corrective actions in case spending goes off path.

Institutionalization

Countries should aim to institutionalize the decision-making process to facilitate ongoing HBP revision and realise a lasting impact.^{54,55} Institutionalization involves a set of activities through which a decision-making process becomes an integral part of a planning system and is embedded in ongoing practices.^{54,55} The institutionalization of HBP design relates to issues such as legal framework, governance, capacity, and funding. As an example: the government in Sudan has prepared a specific document for institutionalization alongside the development of the service package,

Sudan spotlight: Arrangements for institutionalization of the service package

In Sudan, a specific document was prepared for institutionalization alongside the development of the Essential Health Benefits Package (EHBP). This document aimed to suggest a set of governance conventions, management actions, and resources needed to institutionalize the EHBP and related financial mechanisms from 2020 to 2025. The distinctive feature of this document is that the EHBP will ultimately be compatible with the broader governance of Sudan's health system. As the method of developing this document, all essential functions and activities needed through the five-year period were identified. Second, the governance arrangements required for these functions and activities were mapped. Finally, advisory groups and technical panels were defined, as required. The result was a board of national healthcare (chaired by the Federal Minister of Health (MoH), co-chaired by the Federal Minister of Labour and Social Development) for the governance and three subordinate boards for delivery, financing, and policy issues. In addition, EHBP activities will be coordinated by a dedicated EHBP program team that gets inputs from expert panels. The panels cover various EHBP development areas such as education and training or monitoring and evaluation. The responsible bodies for implementation were also defined. The National Health Insurance Fund will hold and disburse pooled healthcare funds. The Federal and States MoH will cover the sustainable delivery of the EHBP by government-owned health resources – and/or in partnership with the private or third sector – and meeting standards and targets for efficacy, safety, and values.

detailing a set of governance conventions, management actions, and resources needed to institutionalize the HBP and related financial mechanisms from 2020 to 2025. The aim is that HBP revision will ultimately be compatible with the broader governance of Sudan's health system. See the Sudan spotlight for more detail. We strongly recommend countries to foster the institutionalization of their HBP revision process.⁵⁴

Dealing with HBP design and revisions in federal states

A special situation arises in countries with a federal system of government, such as India, Nigeria, and Ethiopia.⁵⁶ There may be a generic national-level HBP in place, which lower levels of government may want to customise according to their own preferences and local circumstances. In some instances, representatives of subnational health authorities can be included in the advisory committee or decision making to reflect their experience of implementing the HBP and constraints. The National Health Authority in India, for example, provides stewardship for the design, rollout, and implementation of the country's PMJAY scheme. Individual states have a certain autonomy to make adjustments: they can add services but not omit any. They then adopt and implement their own schemes by integrating pre-existing schemes and aligning them with PMJAY, with different levels of subsidy by the federal government. The India spotlight gives a bit of history on how different health insurance schemes were merged into PMJAY; it also describes how three states then went on to tailor their state-level HBPs to their own local situations and preferences.

India spotlight: State governments customizing the federal-level health benefits package

India runs the world's largest government-sponsored national public health insurance scheme. Launched by the Ministry of Health and Family Welfare in 2018 as *Ayushman Bharat Pradhan Mantri Jan Arogya Yojana* (literally: Prime Minister's People's Health Scheme; or AB-PMJAY or PMJAY), it aims to provide free access to health insurance coverage for India's low-income earners, roughly the bottom 50 percent of the country's population.

While NHA provides the framework for the national level HBP, states have a certain autonomy to make adjustments according to their preferences and local circumstances: they can add services, but not omit any. They then adopt and implement their own schemes by integrating pre-existing schemes and aligning them with PMJAY, with different levels of subsidy by the federal government.

For example, the Government of Karnataka state formed several subcommittees to review both PMJAY and the scheme that was already in place (*Arogya Karnataka*) for various conditions and specialties. Following extensive discussions, the recommendations of these subcommittees were submitted to the overall package review committee, headed by the State Principal Secretary for Health, for endorsement. The main features of PMJAY in Karnataka are:

1. introduction of differential pricing for public and private hospitals;
2. categorization of packages into secondary, complex secondary, tertiary, and emergency procedures; and
3. mandatory referral system except for emergency procedures.

Whereas the national PMJAY covers renal transplants, the HBP in Karnataka state also covers heart and liver transplant surgeries.

Take-away messages

1. HBP revision requires several actions, including the installation of an advisory committee, collection of evidence, and prioritization of services; it is best considered as a stepwise process.
2. Countries are advised to adjust the order and contents of each step to their own decision-making context – for instance, whether they are dealing with a periodic or one-off revision.
3. It is important to ensure fairness of HBP revision. Transparency and meaningful stakeholder involvement are key aspects here and should be taken care of throughout the process.
4. Implementation is essential to ensure services are accessible to eligible citizens and are provided in reality. Implementation requires planning and careful coordination.
5. Institutionalizing the revision process can help facilitate ongoing review and realise a lasting impact.

Chapter 5: Which analytical approach fits best the local challenges?

Countries may have various reasons to revise their HBP, as indicated in Chapter 2. For analytical purposes, we distinguish eight typical challenges that require specific methodological approaches to HBP revision (Table 5.1). In practice, countries may face some of these situations simultaneously, so they may need to combine the corresponding approaches.

These challenges and approaches explicitly recognize that countries should be very selective in terms of the services they evaluate. A country typically only has limited financial and analytical capacity available for HBP revision, and important choices need to be made on where to spend this capacity. In other words, while a whole sector review may seem most relevant from a health systems perspective, it may be a more efficient use of analytical capacity to focus the activities and conduct a partial review, incremental analysis, or rapid review. More information on selection of services for evaluation can be found elsewhere.^{57–59}

Table 5.1: Taxonomy of approaches to HBP revision

Challenges	Potential approaches
A. Concerns about affordability	Whole package review Partial package review Incremental analysis Rapid review
B. Concerns about inefficient services	Whole package review Partial package review Incremental analysis Rapid review
C. Implicit HBP automatically expands with new (costly) services	Revise HBP toward an explicit package with a positive list
D. Pressure to include new services	Evaluate new services with incremental analysis
E. HBP not matching the burden of disease	Evaluate possibly relevant new services with incremental analysis Partial or whole package review
F. HBP needs to be aligned with (updated) health system goals	Partial or whole package review
G. HBP considered unacceptable by stakeholders	Improve decision-making process in terms of stakeholder involvement and transparency
H. HBP services are under- or overutilized	Identify specific reasons

We will discuss each of these challenges and the corresponding approaches.

A. Concerns about affordability

A country may have an HBP that comprises a broad range of services that outstretch the available financial resources. If an increase in financial resources is not possible (see Chapter 7 for discussion on resourcing), then the services may not be delivered at full coverage (i.e., implicit rationing), or the service quality may be compromised. In such a situation, the HBP may need to be narrowed down in one or more dimensions of the UHC cube – that is, in terms of the range of services covered, population coverage, and/or co-payment levels.²⁸ Affordability (and sustainability) concerns formed an important reason to revise the benefits package of the National Health Insurance Scheme (NHIS) in Ghana and the National Health Insurance in Indonesia (see Ghana spotlight B and Indonesia spotlight A).

Ghana spotlight B: Ensuring financial sustainability when reviewing a health benefits package

Anecdotally, it is often stated that the current NHIS benefits package, which covers about 95 percent of disease conditions occurring in Ghana, is too large to be financially sustainable. In 2018, the National Health Insurance Authority (NHIA), in collaboration with its partners, built a new actuarial model that replaced the model that had been in place since 2004. With a higher level of disaggregation, the new model allowed projections of the financial impact of adding new benefits to the package and a more granular assessment of the financial sustainability of the NHIS. Examples of new benefits that were assessed are breast and cervical cancer screening and treatment, HIV/AIDS, childhood leukaemia, screening for diabetes, and sickle cell treatment using hydroxyurea. The actuarial model utilised NHIS claims and membership data, information from Global Burden of Disease studies, national population data, budget forecasts of the Ministry of Finance, and NHIS income and expenditure data to model projections.

It was found that the NHIS would remain sustainable with its current financial inflows if clinical family planning services and four childhood cancers (acute lymphoblastic leukaemia, Burkitt's lymphoma, retinoblastoma, and Wilms tumour) were included in the benefits package. After adding these services in July 2022, the NHIA set out to institutionalize this incremental review strategy informed by projections of the actuarial model. This would ensure that the financial sustainability of the scheme is safeguarded, bearing in mind the capacity of the current earmarked funds to support further inclusions.

Indonesia spotlight A: Containing financial deficits that turned into an unexpected surplus

Due to the comprehensive nature of Indonesia's national health insurance (Jaminan Kesehatan Nasional, JKN) benefits package, the cost to deliver it is high. Without government subsidy, JKN would incur large financial deficits. In 2019, five years after JKN was launched, the government ordered a comprehensive review of the benefits package which was started in 2022.

Meanwhile, the government took several other measures: a rigorous healthcare utilization review to identify potential inefficiencies or fraud in JKN healthcare spending; and the allocation of additional government subsidies, financed partly by a tobacco excise duty.

The government also asked the National Audit Board to conduct an audit to identify the root cause of the deficit, including areas of possible mismanagement. The audit found a gap between the current JKN contribution rate and the actuarial calculation. In early 2020, the government then decided to increase the contribution rate. Around the same time, the COVID-19 pandemic unfolded, causing a significant drop in JKN healthcare utilization as people started shunning health facilities for fear of being infected.

The combination of increased JKN contributions and reduced service utilization then suddenly resulted in a financial surplus. This changed the scope of the HBP review completely, shifting the focus to improving accessibility and quality of care. Fourteen different types of screening to detect diseases as early as possible were added to the service package offered by PHC facilities and included as JKN benefits. The technical arrangements for actual implementation are still under discussion.

There are several methodological options for countries that are planning to trim their HBP rather than increase the budget envelope. An important element is the scope of the challenge: is affordability an issue across the whole health system or only to specific conditions or services?

- If the challenges are relevant to the whole health system, we advise countries to undertake a whole package review. Such a review evaluates the comprehensive set of services in a single concentrated effort and identifies the optimal set of services given the available financial and human resources.⁶⁰ Several countries, including Ethiopia, Pakistan, and Sudan, recently embarked on such an approach, supported by the Disease Control Priorities (DCP) project. This project has made model packages available that countries can use as a starting point for analysis.⁶¹ The Ethiopia spotlight A describes the revision of the essential health services package (EHSP) in Ethiopia in 2019. It should be noted that a whole package review requires considerable analytical capacity and may provide challenges in terms of political will and feasibility of implementation – all factors that should be explicitly considered in the revision process.³¹ Countries can make optimal use of their analytical capacity by focusing their review on evaluating services for which there are concerns about their affordability (stakeholders can play a role in systematically identifying such services).
- Countries may also undertake a partial package review and limit the analysis to specific conditions that are considered problematic and/or urgent. This approach was used in Iran in two consecutive service package revisions for multiple sclerosis and diabetes mellitus type 2, respectively.⁶² For both conditions, stakeholders nominated a range of services that were evaluated in detail. See Iran spotlight for more detail. However, it should be realised that condition-specific analyses preclude resource reallocations between disease areas; hence the gains may be limited.

Iran spotlight: Cluster-wise health benefits package revision

The High Council for Health Insurance (HCHI) coordinates periodic revisions of Iran's health insurance benefits package (HIBP). Since 2019, HCHI has been targeting disease clusters, each involving multiple services. It was decided not to evaluate the whole HIBP in a single effort as this would require much more analytical capacity and preclude an in-depth analysis.

The first revision concerned multiple sclerosis (MS) diagnosis and treatment, for which HCHI used the framework of evidence-informed deliberative processes on a pilot basis. Stakeholders nominated nine services (out of more than 50 services in total), some of which they deemed possibly of low value and/or unaffordable, and a few new services (two diagnostics and two high-tech medications). These nine services were assessed and appraised. Recommendations were formulated on (conditional) service coverage, with a potential reallocation of US\$8 million annually. After their adoption in early 2021, the recommendations were turned into formal policy.

Implementation of the revised MS service package is expected to improve the quality of care for MS patients as well as the financial accessibility of the package, at a zero net budget impact. The legitimacy of decision making was enhanced by involving stakeholders who engaged in deliberation based on available evidence in a stepwise, transparent manner. The pilot project has served to help Iran's health system move faster toward UHC for a broader range of essential health services. The second revision concerned diabetes mellitus (type 2), completed in early 2022. Subsequent revisions are ongoing for hypertension management, breast cancer, and schizophrenia disorders.⁶²

- Alternatively, countries may evaluate individual services by conducting incremental analyses over time, also referred to as “incremental health technology assessment,”¹⁸ in which new services are evaluated against the existing package. Incremental analysis can support HBP revision decisions, for example by preventing the inclusion of low-value services or by supporting price negotiations with manufacturers or service providers. The scope of such analysis is smaller compared with whole package reviews or partial reviews, but the advantage is that it requires less analytical capacity than conducting a full review and may also be less challenging in terms of political will and feasibility of implementation. An example is the work by HITAP in Thailand – specifically its evaluation of dialysis in end-stage renal disease for insurance coverage decision (see Thailand spotlight).

Thailand spotlight: Incremental analysis of dialysis in end-stage renal disease

The treatment of end-stage renal disease is recognized as a serious economic and political challenge in healthcare. Renal replacement therapy is crucial for patients but known to be a very expensive health technology. There are basically three options: peritoneal dialysis (PD), haemodialysis (HD), or kidney transplantation. Previous studies have confirmed that kidney transplantation is the most cost-effective option and is often considered the preferred choice. But in many settings, including Thailand, the number of kidney donors is highly insufficient to meet the demand.

Thailand has been providing health coverage through a tax-based universal coverage scheme (UCS) since 2001. In 2007, this scheme covered a population of 45 million who were not eligible for either the Civil Servant Medical Benefit Scheme (CSMBS) or the Social Security Scheme (SSS). While all three ESRD treatment modalities were covered by CSMBS and SSS, the UCS benefits package covered none of them. This resulted in strong pressure from various stakeholders to provide UCS beneficiaries universal access to at least PD and HD. An incremental cost-effectiveness analysis concluded that offering PD as initial treatment is a better choice than HD. In 2008, PD was added to the UCS benefits package with several other policy measures to encourage healthcare providers to offer PD services.^{63, 64}

- Finally, in the evaluation of individual services, countries may also want to use a rapid review, sometimes dubbed a “low-hanging fruit” strategy. In this approach, analysts systematically scan the HBP for high-cost services for which cheaper alternatives are available (e.g., biosimilars), or for services with limited effectiveness that may then be considered for exclusion from the package. A very nice example is the work done in Vietnam (see Vietnam spotlight).

B. Concerns about inefficient services

A country may have concerns that its HBP includes inefficient services. Such services do not provide value for money, and a country may consider spending its scarce resource on other services that better address the needs of its population. For example, a country that presently invests resources in the expensive treatment of advanced stages of chronic obstructive pulmonary disease, for which there is evidence of inefficiency,⁴ may wish to re-evaluate this investment. Inefficiency can also be rooted in system-related factors, for example in delivery modality. In these situations, countries have the same options as under section A: they can perform a whole package review if the efficiencies are suspected to pertain to the whole health system, a partial analysis if inefficiencies are only deemed relevant to specific conditions, or rapid reviews to systematically identify inefficiencies of individual services (the latter, for example, by identifying very costly services and evaluating whether these are included in treatment guidelines). While a powerful approach to achieve quick gains, the rapid review strategy does not allow assessments of less obvious efficiency gains, for instance shifting services from tertiary to secondary level – this would require thorough comparative analyses of costs, health effects, and quality of services.

C. Implicit HBP automatically expands with new (costly) services

Countries with an implicit HBP, or an HBP with only an explicit negative listing, run the risk that many new (costly) services are covered automatically. As budgets are typically limited, this means that fewer resources are available for other services, which may result in crowding out (underfunding of personnel and/or equipment and compromised service quality). In such situations we recommend countries to revise their HBP toward an explicit package with a positive list. This would imply that all covered services are explicitly listed, and everything else that is not listed is not covered. In this instance, there may still be pressure to add new services to the HBP, which brings up the next issue.

D. Pressure to include new services

Countries with an explicit HBP with positive listing may undergo pressures from stakeholders to include new services. Here, we recommend countries to conduct incremental analysis as described under section A to help generate sufficient evidence to support decision makers. An example is the evaluation of dialysis in end-stage renal disease for coverage decisions in Thailand (see Thailand spotlight).

E. HBP not matching the burden of disease

A shift in a country's burden of disease may imply that an HBP becomes outdated quickly. For instance, many LMICs are undergoing an epidemiological transition toward a greater burden of NCDs.⁶⁵ Changes in burden of disease profiles typically manifest themselves in requests to add new services to the HBP. Depending on how countries have organised their HBP, new services may be automatically covered (which requires the type of remedial actions described in section C) and/or they may need to undergo assessment before an inclusion/exclusion decision can be taken (see advice in section D). If there is a relatively large mismatch between the country's HBP and burden of disease, a partial or whole package review may be required. If the mismatch is not so big, it may be sufficient to evaluate individual services by conducting incremental analyses.

F. HBP needs to be aligned with (updated) health system goals

If a country updates its national health sector strategy, the HBP may need to be brought in line. For example, if a country wishes to strengthen primary healthcare services, it may want to revisit the present spending on secondary and tertiary hospital services. In those instances, we advise countries to follow the approach as mentioned under section A: undertake a whole package review if alignment is required for the entire health system, or else a partial review if alignment is required for specific conditions. The Mongolia spotlight describes the example of Mongolia regarding its intended strategic change from hospital to primary care, including the performed and planned steps toward realisation of this health system goal.

Countries may also want to revise their HBP for equity reasons. If a country runs different schemes for different populations – for example, one for civil servants, one for private sector employees, and another one for all other citizens – it may want to merge them into a single scheme so that everybody is entitled to the same services. This is what happened in India and Indonesia (see India spotlight and Indonesia spotlight B). Another example is South Africa, where the public and private sector have historically operated in parallel, with separate HBPs that reinforced the historical high levels of inequality as well as inefficiencies. The country is preparing to implement National Health Insurance (NHI) as a strategy to accelerate progress toward universal health coverage as part of its reform aimed at creating a single health system. The South Africa spotlights A and B provide further details. Equity concerns also motivated a review of multiple sclerosis (MS) services in the health insurance benefit package in Iran. A subsequent reallocation of resources is expected to improve the financial accessibility and sustainability of MS services.⁶² For more detail see Iran spotlight.

Mongolia spotlight: Health financing reform

In 2020, the Government of Mongolia started implementing a significant health financing reform, shifting from input-based budgeting to output-based funding for all levels of care from a combined pool of state budget and health insurance funds (HIF). This integrated fund is administered by the Health Insurance General Office (HIGO), which has become Mongolia's single purchasing authority. HIGO's mandate now includes evidence-informed health benefits package revision.

The HIF now covers all essential services, including intensive and emergency care for complicated deliveries, stroke, cancer, trauma, and burns. The list of reimbursable medicines has been revised, leading to a 43 percent increase in access over a 12-month period (2020–2021).⁶⁶ Strengthening primary care being a government priority, the tariffs for consultation have been doubled and calculated per capita using geographical coefficient in remote areas. Family Health Centres (FHCs) are funded through the HIF, using a combination of payment for main care categories and for services such as diagnostic tests, home and day care, and rehabilitation.

Four key interventions have improved financial protection of insured people: (1) annual benefit ceilings per person have been eliminated; (2) HIF now fully covers all essential and costly care without any co-payment; (3) seven population groups are now fully exempt from co-payments; (4) primary care centres (Soum Health Centres, SHCs) receive extra financial support used by geographical coefficient, especially those in remote areas.

The funding allocation for FHCs and SHCs combined increased from 17 percent of total government health expenditure to 20 percent. Through tax increases on alcohol and tobacco products, the government of Mongolia mobilizes additional resources for healthy-lifestyle interventions and environmental safety.

Indonesia spotlight B: Merger of multiple health insurance schemes

Indonesia's national health insurance JKN was established in 2014 after the merger of four schemes that targeted different population groups – civil servants (run by Askes Sosial), the poor (Jamkesmas), private-sector workers (Jamsostek), and police and military personnel (ASABRI) – and various district/provincial insurance schemes (Jamkesda). Each scheme had its own benefit package, and they employed different provider payment systems. During the preparation phase of JKN, relevant government ministries agreed that JKN's benefit package would be comprehensive in that it needed to cover all treatments and devices of proven medical necessity. JKN benefits would need to provide Indonesian citizens maximum financial protection from catastrophic health expenditures. There was not going to be any cost sharing.

JKN has two different types of members, with slightly different entitlements: subsidized members whose enrolment is paid for by the government, and non-subsidized members who contribute through payroll deductions or out-of-pocket payments. The former are expected to register at one of the public primary healthcare centres; if admitted to a hospital they are entitled to third-class inpatient rooms (six beds per room). The non-subsidized members can register at either public or private clinics, or with an individual general practitioner; for their hospital care they are entitled to first- or second-class inpatient rooms (two and four beds per room, respectively). Members who prefer better amenities can purchase supplementary private health insurance under what is referred to as the “coordination of benefits” (COB) mechanism.

South Africa spotlight A: A data architecture for an emerging National Health Insurance benefits package

South Africa is preparing to implement National Health Insurance (NHI) as a strategy to accelerate progress toward UHC. The reform is designed to create a single health system from the public and private sectors that have historically operated in parallel, reinforcing existing high levels of inequality as well as inefficiencies. Separate health benefits packages for the public sector and the private sector by design focused disproportionately on primary health care (PHC) and hospital services, respectively, as well as separate systems to plan for, deliver, and track service delivery.

The National Department of Health is establishing a data architecture and resulting database that reflects a positive list of all PHC benefits that will be purchased by the NHI fund from public and private providers. It is called the Service Benefits Framework (SBF) and comprises four modules:

1. Service: List of condition-service pairs
2. Outcome: Patient and population level
3. Resource: Average resource requirements per patient for each condition-service pair
4. Cost: Average cost per patient per condition-service pair

Every benefit is defined using the WHO Family of International Classifications: ICD 11, ICHI, and ICF. Thereafter, a subset of tracer condition-service pairs is delineated across the four SBF modules. Care pathways describe how the national clinical practice guideline is expected to be translated on the South African service delivery platform. They provide concrete (normative) examples of what patient-centred care looks like for different at-risk (prevention) and in-need (treatment) populations. For every visit along the care pathway, the lowest level of the health system at which the visit can be expected to take place is defined with the corresponding average and/or minimum resource requirements. The care pathway, level, and resources are selected based on a multidisciplinary team review of existing policy, equity, and efficiency objectives – and proposed trade-offs, where applicable.

South Africa spotlight B: Transparency in populating the NHI Service Benefits Framework

Initial population of the SBF database is intended to provide a baseline of the services currently available in the public sector, against which the private sector will align its HBP, and to inform a process of collecting evidence required to drive subsequent routine implementation of a deliberative process for priority-setting. However, further development of the SBF is intended to serve a range of purposes associated with strengthening governance through transparency, consistency, and stakeholder participation.²⁷ By being publicly available to different stakeholder groups, it will strengthen stakeholder engagement in a standardised and transparent priority-setting process. By codifying each benefit in terms of existing policy, it will become one part of the national digital information infrastructure used to plan, implement, and track service delivery down to the patient level. It will provide a clear definition of services required to mitigate risks associated with bundled payment such as capitation and will support clear parameters for national procurement and strategic purchasing. Further, it will enable analysis of potential instances of fraud and/or waste and existing policies that are not practical or financially sustainable, thereby indicating the need for review. In this sense, the SBF will provide a foundation for a monitoring and evaluation framework for NHI planning and implementation.

G. HBP considered unacceptable by stakeholders

The composition of the HBP may induce opposition from manufacturers, health professionals, patients, or other interest groups. They may plead for coverage of specific services, higher coverage of included services, or lower co-payment levels for included services. While these stakeholders may have valid reasons for their wishes, it will not always be possible to grant all requests, for reasons of affordability and sustainability.

Here we advise countries to proactively and explicitly involve stakeholders throughout the HBP revision process and raise awareness of the need to make difficult choices. This may lead to a better acceptance of the eventual decision among stakeholder groups, even if the service they prefer is not included in the HBP. There are several examples of stakeholder involvement in HBP revision processes. The HBP revision in Pakistan involved more than 100 stakeholders who participated as members in Technical Working Groups and/or the National Advisory Committee and who all had voting power (see Pakistan spotlight A for more detail). We also recommend countries to make the decision making as transparent as possible, by making decision criteria and justifications for decisions publicly available.⁴²

H. HBP services are under- or overutilized

A country may have poorly defined some of its HBP services in the past, which may now cause an underutilization of these services. For example, concentrating surgery at tertiary level hospitals may create barriers of geographic access as people need to travel relatively large distances. In other instances, inadequate definition of services may also cause overutilization. An example is the implicit expansion of eligibility criteria over time (e.g., ophthalmologists starting to provide glasses to the mildly visually impaired, instead of only to people with moderate visual impairment as per initial guideline). In both instances, we advise countries to investigate such specific service attributes that cause under- or overutilization (for example, by comparing statistics on usage from claims data, medical records, or surveys with indication criteria of the services as defined in treatment guidelines) and to take remedial action.

Take-away messages

1. Countries may face several situations that require a revision of their HBP, including affordability concerns, pressure to include new services, and under- or overutilization of particular services.
2. These situations might benefit from specific methodological approaches to HBP revision, such as incremental analysis or whole package review.
3. In practice, countries may face more than one of these situations simultaneously, so they may need to combine the corresponding approaches.

Chapter 6: Which data and evidence to use in HBP revision?

This chapter provides guidance on the use of data and evidence throughout various steps of the HBP revision process. As described in Chapter 4, this includes the preparatory arrangements (step 1) in which evidence on service coverage is essential to assess and understand the performance of the present HBP. It also includes the assessment of services on the various decision criteria (step 4), for instance on cost, cost-effectiveness, and financial risk protection. For definitions of specific terms, please refer to the Glossary.

This chapter builds on the “Practitioner’s Handbook,” which provides introductory material on the use of evidence for priority setting as produced during the first phase of the JLN Efficiency Collaborative. The Handbook introduces different types of data and evidence and has practical advice on how to address any data gaps available at country level, when to use international sources, and how to institutionalize data and evidence and plan for future data collection needs.³⁵

The generation and gathering of data and evidence are likely to be resource intensive, so analysts should plan to use their time and resources in an efficient manner. This planning will be informed by what resources and existing data and evidence are available, which should be identified from the outset. This will also inform the approach suggested and provide indicative timelines. For instance, if the revision is planned as a full package review, full economic evaluations and systematic reviews are unlikely to be feasible, and analysts will prioritize more rapid approaches. The experience of Chile’s AUGE package, described in the Chile spotlight, further highlights the benefits of establishing a process for periodic reviews, which ensures that data collection efforts and analysts’ time and resources for revisions are planned and channelled effectively.⁶⁷

Chile spotlight: Updating Chile’s AUGE package

In the early 2000s, Chile introduced reforms to reduce social inequalities. As part of this ambitious agenda, the Universal Access with Explicit Guarantees healthcare scheme (known by the acronym AUGE) was developed to help meet the country’s health goals. Chile is one of the rare examples of countries where provisions for periodic revisions (every three years) have been written in law. This has led to a schedule of mandatory technical, epidemiological, and economic studies that support decision making for updating the priority list.

To ensure that this work is carried out in a timely manner, health information systems and statistical and epidemiological tools (including national surveys) were developed to collect data on AUGE and the wider health system. Alongside those, Chile developed a series of studies to obtain national and subnational burden of disease estimates and data on cost-effectiveness and social preferences (although those are not updated as regularly as the rest). Global estimates are also brought in for comparative purposes to complement the national database.

It is worth noting that the country has a long tradition of using data and statistics to support decision making, resulting in a shared understanding of the benefits and development of in-house capacity within the Ministry of Health.⁶⁷

The benefits of using data and evidence are summarised in Figure 6.1.

Figure 6.1: Benefits of using data and evidence



This chapter provides guidance on using seven key types of data and evidence that may inform HBP revisions (Box 6.1). They will be discussed below, with several illustrations from countries' own experiences. Each section will provide an overview of the key types of data and evidence, describing their potential benefits. The sections also provide pragmatic solutions and ways of going forward if there are potential challenges to using such data and evidence.

Box 6.1: Key types of data and evidence for the HBP revision process

- A. Data for estimating health needs and utilization
- B. Evidence on equity and financial protection
- C. Cost data
- D. Cost-effectiveness evidence
- E. Budget impact analysis
- F. Fiscal space projections
- G. Global datasets, models, and tools relevant to revisions

A. Data for estimating health needs and utilization of services under the previous version of the package

While HBPs are designed to reflect the health needs of the population, changes may be expected over time, and an HBP could become out-of-date. This may mean that essential services are not covered or that implementing the HBP becomes financially unsustainable. Routine demographic and health service data can be used to identify when and how the needs of the population change, which can then be the basis for a revision. It can also be used to investigate demand and access to services covered in the previous version, as many countries have expressed concern that the coverage of high-value services in the package is insufficient.

Burden of disease (BoD) data can provide insights as to the underlying health needs of the population, and knowing the observed utilization rates is helpful for forecasting future utilization rates, which can ultimately assist in estimates of future budget impact. BoD is measured in terms of mortality and morbidity – it can be expressed as the incidence and prevalence of a given condition or in terms of Disability Adjusted Life Years (DALYs) due to a particular health condition. Modelled estimates of BoD in each country are produced by the Global Burden of Disease (GBD) study.⁶⁸ National statistical offices also often estimate the disease burden from surveillance and monitoring systems, sometimes disaggregated geographically or by population groups. Survey data sources can further help to collect more granular information on the disease burden. One example is the Demographic and Health Surveys (DHS), although it is worth noting that they focus on Millennium Development Goals and Reproductive, Maternal, Neonatal, Adolescent and Child health indicators, making it non-exhaustive.⁶⁹

Current utilization data can provide an indicator of the expressed demand for services. This is especially relevant in the case of revisions, as many LMICs with an HBP in place collect claims data and as a result will have a good understanding of utilization levels. Service utilization data is especially important for estimating the budget impact of an HBP revision. It should be noted, however, that utilization is not a good measure of health needs, because it is determined in large part by availability and accessibility of services, which may be suboptimal. HBP revisions are likely to alter availability and accessibility, so surveys of unmet need and careful evidence-based forecasting may be necessary during actuarial analysis to try to estimate the impact of the proposed revision on utilization and therefore the total budget impact. In Thailand an unmet-need study was conducted that identified the poor, elderly, and urban populations as being adversely affected.⁷⁰ The results of the study could inform a reallocation of resources to achieve more equitable service access.

Similarly, between July and October 2019, Malaysia conducted a survey entitled the National Health and Morbidity Survey (NHMS) that focused on unmet needs, among others.⁷¹ The survey found a significant amount of previously undiagnosed NCDs in the poorest 40 percent of the population – in particular diabetes, hypertension, and dyslipidaemia. This finding supplemented policy planning and informed HBP revisions as the MOH then widened access to comprehensive health screening by purchasing the services in the private sector. See Malaysia spotlight. The Ghana spotlight C also shows the importance of monitoring utilization to inform budget impact assessment.

Malaysia spotlight*: Data collection for estimating health needs and monitoring service utilization

Malaysia conducted its first National Health and Morbidity Survey (NHMS) in 1986, focusing on disease prevalence and healthcare demand. It was initially meant to be repeated every 10 years, but from 2011 onward, surveys were held annually, each time with a specific focus on a particular condition.

NHMS results have shown increasing trends of disease prevalence, especially of NCDs including diabetes, hypertension, and hypercholesterolemia, that often went undiagnosed among the adult population.⁷² This triggered the Ministry of Health to introduce a nationwide community-based programme in 2013 known by the acronym KOSPEN (*Komuniti Sihat Pembina Negara*). It involves screening undertaken by trained community volunteers and referral to a health facility, if necessary. A study on the quality and cost of primary care in 2015 (QUALICOPC) found that most Malaysians who accessed private primary care clinics were from middle- and high-income groups and attended because they had complaints or had been diagnosed earlier with a certain illness, with only a few coming for routine medical check-ups.⁷³

The Government then introduced an extension to the national health benefits package in April 2019, under PeKa B40 (*Skim Peduli Kesihatan untuk Kumpulan B40*), seeking to increase access to health screening services at private primary care clinics for people aged 40 and above from the 40% lowest household income group. The purchasing of health screening service is conducted by a non-profit company established under MOH.⁷⁴

From July 2019 onward, the NHMS surveys have included questions on health screening utilization, allowing a better understanding of possible changes in the uptake of such services.⁷⁵

* Information not verified by country.

Ghana spotlight C: Estimating utilization rates

The NHIS in Ghana faced financing pressures between 2009 and 2014, in particular operational deficits due to delays in the release of earmarked funds but also as a consequence of rising claims expenditure. Between 2005 (shortly after the NHIS inception) and 2009, outpatient visits increased from 0.4 per capita per year to about 1. The utilization of outpatient services was the largest contributor, but inpatient utilization also increased from 22 to 58 per thousand annually.⁷⁶ The increase in utilization rates was considered to be the result of the implementation of the NHIS. While this was a positive consequence of the introduction of the scheme, the magnitude was financially significant and exceeded the original projections made through actuarial modelling.

One of the main lessons learned was that routine demographic and health service utilization data should be monitored regularly to inform HBP revision, as health needs and service demand may change significantly through the introduction of a scheme and its rollout.

We provide a list of possible data sources available for estimating utilization in the context of revisions, ranked from most to least commonly encountered:

- **Surveillance and health management systems:** Many countries have put in place routine data collection systems to track multiple health statistics covering their territories or selected (ideally representative) health facilities. One example of such systems is the District Health Information Software 2 (DHIS2), which has been rolled out in 60 LMICs.⁷⁷ These systems are typically implemented at the facility level and aggregated by regions or countries.
- **Survey data:** These include surveys such as the DHS but also local health surveys run by country statistical offices. Those surveys, however, may have several drawbacks: methods employed, scope of the information collected (typically centred around specific issues), frequency, and timeliness of the data generation.
- **Claims and pharmacy data:** Insurance claims can provide very useful “big data generated from healthcare encounters.”⁷⁸ They typically collect information by facility and procedure codes. They are stored centrally by the responsible authority and are used to support reimbursement of providers, detect fraud, and track the delivery of their HBPs. A good example of such data is the National Data Warehouse in India, which we discuss in the Practitioner’s Handbook from Phase I.³⁵ In addition, in Indonesia, the Ministry of Health collects claims data to document utilization, and this data is reviewed on an annual basis to identify the need for revising JKN’s HBP or National Formularies (for medicines). Unlike survey data, one advantage of this type of data is that it is routinely and continuously collected and can be up-to-date and used for generating trends or statistical analyses without additional survey costs.
- **Electronic medical records (EMRs):** EMR is a “longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunisations, laboratory data, and radiology report.”⁷⁹ However, EMRs are still not commonly implemented in LMICs (despite the recent increase in uptake), and the scope of EMRs may be very limited (to certain types of facilities or to certain type of conditions) and therefore not commonly used for estimating utilization and needs.⁸⁰
- **Estimates from other regions, countries, or insurance schemes:** In Kenya there are two insurance schemes operating in tandem, which have provided a wealth of data and cross learnings. Comparing coverage and utilization rates allowed both schemes to build upon and leverage the knowledge already gained and improve their own offerings.

B. Evidence on equity and financial protection

While it is important to use evidence to ensure that the HBP delivers good value for money and is financially sustainable to deliver, most countries also use additional decision criteria such as equity and financial protection.

While existing guides provide support on including these objectives in HBP revision, there is no universally agreed framework or method for doing this.^{18, 27, 31–34} Here we encourage countries to explicitly state their equity and financial protection objectives at the outset of a HBP revision, collate data and evidence on the likely impact of major HBP decisions on these objectives, and set up evidence-informed deliberative processes to inform the choice of high-priority services.³⁴ The benefits of such an approach are clearer transparency, better stakeholder engagement, and closer alignment of the HBP with societal values.

Examples of countries that use local data to inform estimates of equity and financial protection:

- Ethiopia made extensive use of stakeholder engagement and a Delphi method to identify the services that were most likely to lead to financial catastrophe and assess their inclusion in the benefits package.^{12, 49} See Ethiopia spotlight B for more details. Stakeholders also compared services' ability to address inequality in disease distribution, particularly across regional differences. Similarly, in Thailand dialysis was added to the HBP for financial protection reasons.
- Indonesia identified differences in utilization between socioeconomic groups and regions by assessing data from the public health insurance scheme JKN. The main cause for discrepancies in care appears to be the geographical spread of the country, which limits access in the most rural areas. To address this, Indonesia is promoting the use of telemedicine, which can make access to services more equitable across the country.

Ethiopia spotlight B: Equity assessment in the Ethiopian EHSP using the Delphi method

Equity is a policy commitment to create a fair and just society and a pro-poor health system. Ethiopia applied the equity criterion to give priority to interventions that target diseases, conditions, and risk factors that mainly affect poor people. Those who are generally worse off in Ethiopia are children below age five, pregnant women, low-income groups, and populations living in remote areas. They are at relatively higher risk to contract childhood diseases, have complications around birth, and be exposed to malaria, tuberculosis, and neglected tropical diseases.

Using the Delphi technique, a panel of experts was asked to give scores to a range of interventions on a scale from 1 (low) to 5 (high) equity impact. The experts were selected from different MOH departments, academia, professional associations, and civil society organisations. Health interventions were compared based on their equity scores along with other criteria (e.g., cost-effectiveness) to come up with a priority list.⁴⁹

Certain health services were considered to have a social value that cannot easily be quantified and is therefore difficult to capture in usual assessment frameworks, which typically give much weight to the cost per DALY averted. Examples are palliative care, family planning, in-vitro fertilisation, legal abortion, and some diagnostic procedures (where health information may have value in itself). Ethiopia's EHSP revision demonstrates that the Delphi technique can be applied to incorporate equity considerations and financial risk protection in making trade-offs.

C. Cost data

Good quality cost data are essential to ensure that revisions to HBPs can be delivered sustainably within the available budget.⁸¹ Costing revisions to the HBP can help to estimate total resource needs, inform inclusion decisions at the margin, and negotiate payment rates with providers.⁸²

Cost data have a range of important uses in HBP revision:

- More accurate national cost data will help in making better decisions regarding revisions, as they improve the ability of purchasers to establish prices and price signals that align with costs, reducing under- and overpayment and thus optimising the efficiency of services.
- Cost data can also be used to inform cost-effectiveness analyses and budget impact assessments and thus provide more accurate assessments of a service's value for money and budget impact. In turn, these assessments can inform decisions to add or remove services and thereby optimise the efficiency of the HBP.
- Capturing the expected costs of the revised HBP is essential to help align the HBP with the available resources and may facilitate conversations with the Ministry of Finance for setting budgets (Chapter 7).

However, not all countries have access to local cost data, and it takes considerable time and resources to conduct costing studies and to translate cost data into concrete proposals to decision makers.^{4,81,82} Therefore an important question is: where to begin and how to start using cost data to inform HBPs?

Insights from EC member countries on setting up costing systems

EC member countries have learned valuable lessons on developing a sustainable system of costing and using cost data. A costing exercise can be a starting point, but it is important for countries to do this regularly to ensure that their cost estimates are up-to-date.

To implement costing studies, which can be resource intensive, one option is to work with research institutions and development partners who can provide expertise and guidance. In Laos, the National Health Insurance Bureau (NHIB) began by conducting a local costing study with financial and technical support from several development partners and inputs from several national actors, mainly the NHIB, the Lao Tropical and Public Health Institute, and the Department of Finance, Ministry of Health. It took almost three years to complete. Laos then worked with the WHO to translate the study results into policy proposals. Working with development partners helped Laos decide what to cost and how. Ultimately it was necessary to conduct three separate costing exercises: the essential health service package (121 services), the national health insurance benefit package (142 services), and a separate health facility costing study. The NHIB is preparing to propose an update of the health insurance benefits package to suit the current situation for the government to approve and move towards UHC. It is anticipated that the final output will be used by the Ministry of Health to estimate future funding requirements, inform provider payments and also help to implement a national health insurance scheme.

Laos' approach used detailed methods that provided good insight but required more time, resources, and partnerships. Other EC countries report that selecting a costing method that is too complex can generate a significant administrative burden in the development, implementation, and running of a cost system; therefore it is best for countries to select a costing method that can be conducted within the resources and capacity available. Most countries begin with relatively simple methods and gradually add complexity as further insights are gained and local capacity expands. It is important for countries to work toward developing a sustainable approach to more detailed costing.⁴

India has developed a series of facility-based costing studies over the last eight years. Data from a multisite costing from primary through tertiary level care have been compiled in a national repository of costs and further analysed using econometrics to make state-level predictions of unit costs. Building on this experience, the DHR supported the national study "Costing of healthcare services in India" (CHSI).⁸³ The CHSI sampled 52 public and 40 private hospitals in 13 states and used a combined bottom-up and top-down costing approach. Micro-costing (the assessment of costs at the individual level) was not feasible due to the lack of individual data on resource use. The use of electronic health records could have facilitated the process of data collection to help make micro-costing possible.

In addition to costing methods, it is important to know where to find and access sources of data. Advice from Mongolia suggests that having good IT systems in place is helpful to identify appropriate sources of cost data. Data are collected from health insurance claims on a monthly basis and used to inform the benefits package and provider payments. These data are local, reflective of actual usage rates, and straightforward to collect with a compatible

IT system. Ghana costed health services using data from provider sites that were analysed by a multistakeholder team of experts to develop NHIS tariffs for various levels and types of facilities.

There are also tools available dealing with costing for health benefits policy, such as the JLN for Universal Health Coverage Manual on Costing of Health Services for Provider Payment, which shares experiences and solutions to common challenges related to costing for provider payment in JLN countries, or the OneHealth costing tool, which presents detailed components of existing disease-specific costing tools in a uniform format and links them together.^{84,85} The tool provides a single framework for planning, costing, impact analysis, budgeting, and financing of strategies for all major diseases and health system components, such as human resources, facilities, equipment and transportation, medicines and supply chains, health management information systems, monitoring and evaluation, governance activities such as policy and advocacy, and activities related to financing and administration.⁸⁶ A recent study found that the OneHealth tool was one of the most commonly used softwares by LMICs for costing analysis.⁸¹ The OneHealth tool can provide an excellent starting point, due to the transparency in how cost estimates were developed, but it may benefit from country-specific validation and adjustments to ensure that the costs used are truly relevant.⁸¹

In addition to the collection of data, it is important to put in place mechanisms to ensure that the costs are used during the decision-making process.⁴ This requires creating an institutionalized process as proposed in Chapter 4. In Ethiopia, the Health Insurance Package Revisions prioritization process includes a costing team comprising 8 to 10 members who use service-level costing. The cost estimates may be later used to inform health insurance premiums and define the level of subsidy needed to make the HBP sustainable. This information is directly used to determine the services covered in the HBP.

D. Evidence on cost-effectiveness

Cost-effectiveness analysis, which is a method that quantifies the costs of a service to the health system in relation to the anticipated benefit compared to the standard of care, is often used for HBP development and revision. The incremental costs of the service in comparison to the standard of care divided by the incremental benefit is known as an Incremental Cost-Effectiveness Ratio (ICER).¹⁷ The ICER is the cost of one unit of health from the perspective of the analysis, such as the health system or the society. The use of an ICER allows consistent comparison of value for money across all services.

As stated in Chapter 4, many LMICs are increasingly using evidence of cost-effectiveness to inform incremental additions in benefits package reviews.⁸⁷ In Malaysia, for example, the findings from cost-effectiveness and budget impact analysis are used to decide which drugs are included in the formulary. Submissions are made by pharmaceutical manufacturers and reviewed by an expert committee to decide whether to include the drug based on the overall available budget. Many countries are using cost-effectiveness evidence within a broader framework called health technology assessment (HTA). HTA is a multidisciplinary process that uses explicit methods, including cost-effectiveness analysis among others, to determine the value of a health technology. The purpose is to inform decision making in order to promote an equitable, efficient, and high-quality health system.⁸⁸ There are different ways of implementing HTA. In the Philippines, for example, an HTA committee has been established in the department developing HBP revisions. This in-depth HTA approach is particularly appropriate for an ongoing, incremental approach to HBP revision as described in Chapter 5. Advice on building HTA processes in country can be found in the iDSI HTA toolkit.¹⁸ Advice on planning, conducting, and reporting economic evaluations can be found through the iDSI Reference Case.⁸⁹

When carrying out a more ambitious whole or partial HBP revision, all EC member countries agree that economic evidence can provide useful insight, but all struggle with generating and implementing such evidence as part of their HBP revisions framework for the following reasons: First, developing such evidence requires capacity and training, and formal institutions need to be in place that can conduct assessments and implement the recommendations into the decision-making process. Second, HBPs can include hundreds of services, and most countries do not have sufficient capacity to assess all the services needed. Third, even if capacity were available, there is not enough time to assess all services in an HBP simultaneously. Finally, making truly informed local assessments of cost-effectiveness requires good quality data (particularly cost data), which many LMICs lack.

Potential solutions for incorporating data on economic evidence into HBP revisions when there is not capacity to conduct all of the HTAs needed are to leverage and adapt globally available secondary evidence or adapt the traditional HTA process for more pragmatic evidence generation.^{90,91} This can be done for incremental additions

to the package or as part of a broader rapid review.⁹² Use of such adaptive methods can not only save time in generating HTA evidence but also potentially inform prioritization so that resources and capacity can be directed to the questions where there is the greatest need. There is no singular, globally formalised framework for adapting HTA methods, but many countries are exploring the use of translating evidence from other contexts or using rapid assessments.⁹³ For many services there will be cost-effectiveness evidence available from various sources, for example a study published in the literature, recommendations from international HTA agencies, the WHO guideline “WHO package of essential noncommunicable (PEN) disease services for primary health care in low-resource settings,” and resources such as DCP3 or the Tufts CEA Registry.^{61, 90, 94, 95} The HIPtool uses data from both of these sources and allows users to recalibrate ICERs to adapt them to the local context to inform optimized resource allocations (see section G).⁴⁸ The Pakistan spotlight C describes the use of the HIPtool in the country.

Pakistan spotlight C: Whole package review

In 2019–2020, the Ministry of National Health Services, Regulation and Coordination of Pakistan undertook a national whole-package review of its Essential Package of Health Services to achieve UHC (as part of the DCP3 project). It made use of the Health Interventions Prioritization tool (HIP-tool), a digital tool that can be used to analyse and prioritize health services and to visualize the results of specific prioritization choices in terms of disability adjusted life years (DALYs) avoided and budget impact.⁹⁶ It allowed optimization of a set of 218 health interventions (grouped into five healthcare delivery platforms), based on a set of predefined criteria that included budget impact. This review resulted in an “Investment Cascade of Interventions” and the realisation that implementation of the total package was much more expensive than the available budget. In 2020, total health expenditure per capita in Pakistan was US\$45, of which public spending on health formed around US\$14 (US\$7–8 for district-level services).⁹⁷

It is important to note that all of these sources of evidence need careful appraisal to consider their transferability to the local setting, priorities, and health system, but it may be an efficient way to include economic evidence in the HBP revision process.

An example of this comes from Ethiopia, where the HBP revision prioritization process begins with the development of a master service list, which then goes through a five-step prioritization process that includes cost-effectiveness analysis (see also Ethiopia spotlight A). A mix of evidence is used to generate estimates of cost-effectiveness. This includes a de novo context-specific analysis using the WHO’s CHOosing Interventions that are Cost-Effective (WHO-CHOICE) methodology to assess services and leverage available evidence through a literature review of the above CEA databases, supplemented with other peer-reviewed articles that were interpreted with the local context in mind using the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) 10-point checklist.^{49, 98, 99} This process could be strengthened by developing a national roadmap for HTA that could formalise the processes and help build capacity.¹⁰⁰ However, while this framework still requires a considerable amount of time, effort, and expertise to deliver – and support by international partners – it is a pragmatic way of getting evidence on cost-effectiveness into decision making.

E. Budget impact analysis

Budget impact analyses (BIA) are used to estimate the likely change in expenditure to a specific budget holder resulting from a decision to reimburse a new healthcare service or some other change in policy at an aggregate population level.²

Estimating the likely budget impact of an HBP revision is a useful tool to determine affordability and is often a crucial criterion to inform inclusion/exclusion decisions. If a particular service package or individual service has a large budget impact that exceeds the available financial resources, it may be considered unaffordable, and this can be a reason to exclude it from the HBP or limit eligibility for the service. In the absence of a significant budget impact – due to a relatively low unit cost for a service that is used on a limited scale – the proposed revision may be quickly adopted, provided of course that other key requirements (effectiveness, patient safety, cost-effectiveness) are met.

In the case of revisions, the use of BIA evidence allows an assessment of the expected changes in national health expenditure as a result of implementing a particular benefits package decision.

Such an analysis requires reliable estimates of future service demand, demographics, health behaviours, and possible price changes. The validity of BIA results must consider the quality of the evidence and any uncertainty in the data. Often price data are not always easily available, and it is not always clear what the future price of a particular commodity or service will be, especially in view of changes in demand and demographics, possible price/tariff negotiations with manufacturers or providers, and expiry of patents. To address the uncertainty in the data, budget impact analyses may involve the development of various scenarios, sometimes with wide-ranging cost implications.

F. Fiscal space projections

One often-neglected way to inform the revision of an HBP is to conduct a fiscal space projection. Fiscal space may be defined as room in a government's budget that allows it to provide resources for a desired purpose, such as an HBP revision, without jeopardizing the sustainability of its financial position or the stability of the economy¹³, or crowding out expenditure in other sectors needed to achieve other development objectives, such as some of the non-health Sustainable Development Goals.^{101, 102}

Projections of the available fiscal space and comparisons with budget impact analysis are not easy to conduct but are very important as they provide critical insight as to whether or not a particular HBP revision is actually affordable.¹⁰³ Ethiopia spotlight C describes the process used in the country and the estimate of the resource gap.

Ethiopia spotlight C: Fiscal space projections

Researchers in Ethiopia estimated the financial resources required to implement the EHSP over a 10-year period (from 2020 to 2030).¹⁰⁴ They then predicted the fiscal space for health, using assumptions for economic growth, government resource allocations to health, external aid for health, the magnitude of out-of-pocket expenditure, and other private health expenditures as critical factors.

To implement the EHSP, US\$94 per capita would be required in 2030, for a total of US\$13 billion. However, the expected available resources based on a business-as-usual fiscal space estimate would be US\$63 per capita, suggesting a gap (as a percentage of the required resources) of 33 percent. The resources needed for EHSP implementation would increase steadily due mainly to the gradual increase in service coverage targets. Allocating gains from economic growth to increase the total government health expenditure could partly address this gap. Apart from uncertainties around future economic growth and development partners' financial contributions to health-sector development, an important limitation of the study was that all estimates pertained to the country as a whole. In reality there is significant heterogeneity among the 11 regional states and two administrative councils that form the Federal Republic of Ethiopia, not only in burden of disease profile and health service coverage but also in infrastructure and financial resources for health. Separate iterations of fiscal space projections will therefore be required for various regions.

Fiscal space projections may benefit from additional analyses such as actuarial analysis to project utilization rates and likely income from employment-based insurance premiums.¹⁰⁵ There have been some recent success stories with actuarial modelling. Armenia partnered with the Asian Development Bank to produce a tool that could evaluate various health financing policy options.¹⁰⁶ Ghana's NHIS has used an actuarial model to project the impact on sustainability of the scheme with the possible addition of clinical family planning services and treatment for childhood cancers.¹⁰⁷ Modelling was based on the number of patients and costs of treatment, and the results were fed into the decision to include family planning services in their HBP. Use of global tools such as the HIPTool can estimate the optimized resource allocation within defined resource envelopes.

We discuss the use of fiscal space analyses further in Chapter 7.

G. Global datasets, models, and tools relevant to revisions

Over the last decade there has been a significant improvement in the availability of global datasets, analytical tools, and models to support benefits package revision: for example HIPtool, OneHealth Tool, Tufts CEA Registry, WHO-CHOICE, IHME, and the FairChoices DCP Analytics Tool.^{61, 85, 95, 96, 98, 108}

As an example, the HIPtool provides a platform assisting countries in selecting, synthesizing, and translating global evidence to their own health system's context to inform their health resource allocation processes. As the tool is based on publicly available global information, it can assist in bridging local data gaps, but the tool also allows for customisation so that the data can be more reflective of real-world conditions in country. Combining multiple sources of data allows the HIPtool to calculate the potential health impact of related health system expenditure. In three case studies, the HIPtool showed that optimized spending could avert 26 percent of DALYs in Armenia, 22 percent in the Côte d'Ivoire, and 49 percent in Zimbabwe, rendering it a powerful tool for informing discussions around HBP revisions and spending prioritization.⁴⁸

The example of the HIPtool illustrates how the combination of global evidence, local data, and an appropriate analytical tool can both inform and rapidly speed up the process of HBP revision and can enable committees in their deliberations to explore a range of options while considering the budget constraints. But the tool still requires customisation and training of local staff to adapt the findings to the local context; as a result it works best when models rely on local data.

However, substantial expertise is required to understand the strengths and weaknesses of many of the current datasets and tools and to sufficiently adapt them to the local context. There is no common resource that outlines the differences between the various available datasets and models in terms of their functionality, strengths, and limitations. We therefore advise countries to consult networks of experts such as the JLN and iDSI to provide insights from other countries who have experience in using these tools.

Take-away messages

1. Data and evidence are essential to achieving a high-quality HBP revision. They are required to assess the performance of the present HBP, to inform the prioritization of entitlements, to project the required resources, and to assess the necessary fiscal space.
2. Using evidence within deliberative processes to revise the HBP helps to ensure it aligns with its stated objectives.
3. Most countries will find the availability and use of data and evidence challenging; therefore we encourage focusing efforts on developing sources of data and evidence that will grow in complexity over time.
4. An evidence-informed process that makes full use of evidence and acknowledges its limitations is more likely to be seen as fair by stakeholders, enabling decision makers to justify why a decision was made and explain the trade-offs. This ensures maximum buy-in and increases the likelihood of adequate funding and successful implementation.
5. Accurate fiscal space projections and budget impact analysis can ensure HBPs are implementable and prevent aspirational packages being developed, which can otherwise result in implicit rationing and high levels of inequity and inefficiency.

Chapter 7: How to engage in a successful policy dialogue with financial authorities?

Aligning the revised HBP to its corresponding new budget envelope is a crucial part of a successful revision process.²⁷ To achieve this, Ministries of Health need to engage with Ministries of Finance throughout the revision – a process that can be fraught with challenges. Not only do the mandates of the two agencies differ significantly, they often lack common language, systems, priorities, and incentives.¹⁰⁹ Broadly speaking, the mandate of the Ministry of Finance includes (among many roles) developing the general government budget against competing Ministerial demands; exerting internal financial control and compliance to the approved budget; and ensuring that, in the long term, committed spending does not threaten the sustainability of the public finances of the entire government.^{109, 110} On the other hand, the Ministry of Health is tasked (again, among many other roles) with defining and implementing policies to address sector priorities and with advocating for appropriate resourcing to fulfil its programme of work (e.g., by preparing budget requests and other financial analyses).

A publication prepared by the Senior Budget Officials (SBO) network sheds light on the respective preconceptions that may hinder successful collaboration, some of which are directly relevant to the topic of HBP revisions.¹¹⁰ For instance, the sustainability of health budgets and policies is often called into question by Ministries of Finance because of rising costs, rising burdens of disease, population growth, perceived limitless demands for quality healthcare, and continual addition of new, expensive treatments. The demand from citizens for quality healthcare is also strong; as a result, plans to introduce or revise UHC plans become highly politically charged, especially if the Ministry of Health is not perceived as adequately equipped to deliver on the agenda. Finally, unlike other public investments, the outputs created through investing in health can appear unclear, and Ministers of Finance are wary of open-ended guarantees to citizens, a relevant consideration in countries where HBPs are implicit.¹⁰⁹ On the other hand, Ministries of Health often perceive fiscal sustainability as a constraint, not necessarily an objective in and of itself.¹¹¹ Moreover, the Ministry of Health may view its relation to the Ministry of Finance “through the lens of resource capture” – that is, to request more funding – sometimes at the expense of successful collaboration.¹⁰⁹ Ministries of Health may also feel that public finance discipline, as advocated by the Ministry of Finance, can strain overstretched resources, be inflexible, and limit the ability of managers to respond to emerging priorities.¹¹² Finally, the Ministry of Health may feel that the Ministry of Finance is limited in interpreting and effectively applying economic analyses or other analytics. Being mindful of those preconceptions can help tailor communication and engagement modalities.

For those reasons, adopting a collaborative approach, translated through institutional mechanisms and implementation of public management tools, may help ensure that HBP revisions get a fair hearing from all parts of the government concerned. In this chapter we discuss (a) the role of the Ministry of Finance in HBP revisions, (b) the persuasiveness of fiscal space projections, (c) the importance of embedding HBP revisions within the broader framework of public finances, (d) identification of risks and creation of expenditure tracking mechanisms, and (e) institutionalizing a structured policy dialogue.

A. The role of the Ministry of Finance in HBP revisions

EC countries emphasise the need for the Ministry of Health to work closely with financial authorities to achieve HBP revisions, but they also report that the roles and responsibilities of each agency are often not often well defined. It is important to remember that, while the Ministry of Finance should be involved throughout the revision process, they are not typically involved in the decision making around particulars of the HBP revision – for instance, in suggesting individual services to be included or excluded.¹¹⁰ Their role from the outset is to (i) provide guidance on the rough available budget space; (ii) observe and collect information that will help assess whether the financial implications of HBP revisions are credible, feasible, and sustainable; and (iii) to ensure that, once a revision is decided upon, the funds are used as intended and adequately accounted for. In other words, the Ministry of Finance supervises the macro-fiscal implications of the revision policy. Moreover, the Ministry of Finance will review how the plans to revise the HBP fit within the overall government objectives.

In reference to the framework for HBP design and revision developed in this resource (summarised in Figure 4.1), collaboration between the agencies is particularly crucial in the following steps:

- Step 1 (make preparatory arrangements): when the Ministry of Finance can provide early estimates of budgetary space, provide overall comments on the revision's objectives, and learn about the prioritization methods and process;
- Step 7 (develop HBP as an implementable plan): when the ministries can work together on not only the overall funding of the revision but also the short-term resource needs for implementation; and
- Step 9 (M&E): when the Ministry of Finance can help develop M&E frameworks, especially on data collection and financial assessments.

B. Fiscal space analyses can facilitate often-difficult discussions around matching the revised HBP to a budget envelope

As discussed in the data and evidence section (Chapter 6), fiscal space projections can help structure discussions about the size of the package. There are two alternative approaches: first broadly calculate the available fiscal space and only then define the HBP within the available resources (estimated through costing of services), or first define the HBP and thereafter calculate whether its cost falls within the available fiscal space. Most countries follow the latter approach, but the former one is preferable since it helps prevent overoptimistic or unrealistic planning (sometimes referred to as aspirational or fundraising benefits packages).¹¹³ Some experts make the case that aspirational or fundraising HBPs, combined with fiscal space analyses, have the potential to contribute to increased national revenues for HBP implementation. But there is little empirical evidence that this has actually been the case.¹⁰² Instead, many EC members report the outcome tends to be an underfunded HBP with serious financial constraints. This may result in geographical inequities in service coverage, incomplete coverage of high-value services, or services becoming implicitly rationed through mechanisms like waiting lists. It is one of the most common causes of HBPs failing to impact on population health and undermines the very purpose of explicit, evidence-based HBP revision. However, the calculation of the available budget space is an iterative process in which the Ministry of Health, in collaboration with the Ministry of Finance, can demonstrate the value of the revision decisions and advocate for greater fiscal space.

In addition, a fiscal space analysis may include identifying options for funding the revised HBP (assuming its implementation will require additional resources). Additional fiscal space in health can originate from the following sources: economic growth, reprioritization of the health sector in the budget, sector-specific revenues, external resources, and efficiency gains.¹⁰² A more recent addition to this literature also emphasizes the potential of improved public-finance management practices in increasing budgetary space.¹¹⁴ Raising sector-specific revenues includes introducing insurance premiums, earmarking existing taxes, generating new taxes, or increasing the rate or base of existing taxes. Implementing such mechanisms requires not only the buy-in of the Ministry of Finance but also incremental or new administrative processes and commitment of significant human resources and political capital to mobilise, process, and allocate new resources.¹¹⁵ Ministries of Finance may also be cautious about increasing such revenue sources because of their potentially distortionary effects on the wider economy.¹¹⁰ Because entitlements can be added and others removed during a revision, more budget for additions can be created by removing low-value services or achieving other kinds of efficiency gains.

The use of external resourcing in funding HBP delivery has been explored in recent literature.^{29, 116, 117} This could be very relevant in countries where donors play a significant role in funding healthcare: in Zambia, for instance, close to 45 percent of current health expenditure comes from external partners and is channelled through vertical programmes. While the intention of the National Health Care Package (NHCP) was to pool funding from government and external sources, in practice there was no mechanism to pool and channel those funding streams to deliver the HBP, and its implementation remains unclear to this day.¹¹⁶

C. Embedding the HBP revisions within the broader framework of public finances

As highlighted by EC members, revision decisions are often initiated by a political need and, as a result, can be misaligned with the country's budget cycles. (For a more extensive discussion of how the budget cycle relates to priority setting, see the Practitioner's Handbook developed for Phase I of the EC.)³⁵ In countries where revisions are planned periodically, a better alignment of the policy and budget cycle can be achieved.

The financial planning of the revision will therefore have to be embedded within the broader framework of public finances. Being mindful of the different budget cycle calendars can ensure that the HBP revisions are reflected in the engagement of the Ministry of Health during the government budget preparation phase.

In the short term, costing analyses can help estimate requirements for implementation, which in turn must be translated into a set of short-term funding requests to be included in the sector's annual budget.³⁵ Those requests will need to focus on the direct costs to the healthcare system, and therefore use quite a narrow scope. They will only be successful if the revisions are costed in a convincing and accurate manner, reinforcing the need for this type of evidence in the HBP process overall.

In addition to those annual estimates, it will be important for the Ministry of Finance to have a multiyear vision of the HBP resourcing needs. The actuarial model built for the fiscal space analysis will be crucial in projecting the costs in the medium term, using complex methods that will include rising costs, demographic changes, evolution of utilization rates, and so forth. Those can be included in the medium-term expenditure framework (MTEF), which sets out the spending plans for the health sector, usually on a three-year (or more rarely five-year) basis. The role of the MTEF is to set multiyear spending targets and ceilings to improve the planning of the fiscal policy and better link funding to government objectives and results, although it is not typically binding in the same manner as an annual budget.¹¹⁸ Working with the Ministry of Finance to produce estimates for the MTEF can help signal good financial planning and management. The MTEF can also include financial contributions from development partners (donors) or private parties, if those partners contribute to the delivery of the HBP and are able to program funds in a predictable manner.

Long-term budget planning (10+ years – in some cases up to 50 years) is rarely used, and evidence from OECD countries points to the limited value of such tools.¹¹⁰

In addition to those budgeting tools, the revisions should be clearly linked with the sector's strategic plans and long-term government strategies, which often include health-related targets (or, failing those, employment or social targets). For instance, when revisions of the NHCP were initiated in Zambia in 2019, the Ministry of Health used the targets set out in the country's *National Long Term Vision 2030 (Vision 2030)* to frame the need for revisions and the approach.¹¹⁹ The National Long Term Vision makes explicit references to the role of health in the prosperity of the country, in particular to tackle “major diseases such as tuberculosis and malaria” and to bring under control the HIV/AIDS pandemic “with a progressively reduced incidence rate in both urban and rural areas and among both men and women.”¹²⁰ Actively linking the revision objectives to such policy objectives will also help demonstrate the value drawn from the revisions in increasing the performance of the HBP overall, which is, as we have discussed, often a constraint for Ministries of Finance.

D. Identification of risks and creation of expenditure tracking mechanisms

Finally, the Ministry of Finance will be very concerned with potential risks that would impact the HBP financial forecasts. To address this, the creation of a risk registry that identifies sources of risk for potential overspend (or underspend, though that is less common) should be envisaged. Actuarial models can help identify potential risks stemming from increased utilization rates (as was the case with the NHIA in Ghana), expansion of coverage, or demographic pressures (and the corresponding evolution of disease burdens).⁷⁶ This is an area where an explicit HBP may be easier to appraise. The more concrete the services that are implemented, the conditions that they address, and the disease burden that can potentially be reduced, the easier it will be to identify such risks. The explicit nature of the HBP can also help alleviate concerns around open-ended guarantees made to citizens, which may be seen as threats to the HBP's financial sustainability.

A difficult yet crucial component of a successful HBP delivery (and of future revisions) is the strengthening of expenditure tracking and information management systems and capacity at the level of the Ministry of Health or insurance agency to exert financial acumen. A lack of integrated financial information systems results in “large discrepancies in reported spending and revenues, poor control on financial management, and corrupt practices,” yet even OECD countries struggle with the collection of timely spending data.^{109, 110} Such data, analysed through periodic spending or budget reviews, can also ensure that spending is on path and minimize the risk of breaking spending targets.¹¹⁰ Many OECD countries introduced early warning systems relating to spending, although there is limited evidence on the use of such mechanisms in LMICs. Expenditure tracking can also ensure that the funds are used as intended and has been shown to reduce corruption, which is a key concern for the Ministry of Finance.^{109, 121} Such data can also inform the landscape analysis at the initial stage, by providing information on cost drivers and use (approximated by spending) per service or broad category of service.

Further, the Ministry of Health can raise strategies to address the identified risks: examples include the use of pharmaceutical formularies, mandated generic substitution, definition of multiyear spending ceilings, changes in provider payment mechanisms (to those that favour cost-containment such as capitation), and the use of HTA analyses to inform future revisions.

E. Institutionalizing a structured policy dialogue

Countries can do better by developing and institutionalizing a structured policy dialogue between health and financial authorities, for example through annual or biennial formal meetings during which HBP revisions are discussed. A health policy dialogue is defined as “an evidence-informed, deliberative dialogue process among multiple stakeholders for vigorous and comprehensive policy and practice decision making.”¹²² The benefits of such a dialogue include the building of consensus across different stakeholders, priority setting, and ownership, resulting in overall stronger policies and strategies. A project covering this topic highlights some practical suggestions to support a policy dialogue :¹²³

- Appointing an officer for informal information sharing and liaison between the different institutions
- Developing appropriate staffing at the Ministry of Health (including health economists) to assist with long-term planning and generation of information and evidence that are needed in dialogues with the Ministry of Finance
- Using the forum to form consensus on goals and develop an understanding of each institution’s working environment and practices
- Linking decisions to specific health outputs to improve M&E and establish value and impact
- Developing the capacities of Ministry of Health staff, especially for their arbitration and negotiation skills
- Offering training to understand budgeting practices, including on the medium-term expenditure framework

The JLN Domestic Resource Mobilization (DRM) collaborative developed a Policy Dialogue Toolkit¹²⁴ to engage finance stakeholders around health sector financing goals. It is a set of coproduced, tried-and-tested materials from various workshops, meetings, and proceedings that have been used by more than 100 senior policymakers across 20 low- and middle-income countries in Africa and Asia.

The collaborative also produced a messaging guide for domestic resource mobilization, titled *Making the Case for Health*.¹²⁵ It is a compilation of messages and related, practical country examples that can be used by health authorities to frame rationales for investing in health by conveying arguments that resonate better with financial authorities. This type of messaging can be very helpful in clarifying the value of revisions, along with the financial information provided in fiscal case analysis, especially linking health to other sectors’ objectives such as employment or education.

Moreover, engaging networks of budget officials can help in understanding how to communicate and work effectively. The Senior Budget Official (SBO) network for OECD countries and the Collaborative Africa Budget Reform Initiative (CABRI) regularly bring together representatives from both ministries and produce useful reports and analytics that may help countries tailor their communication.

Take-away messages

1. The lack of common language, procedures, and systems, and differences in mandates and roles, can affect the ability of the Ministry of Health and Ministry of Finance to collaborate effectively.
2. Fiscal space analyses can help ensure that HBP revisions are feasible and sustainable, by ensuring that the revisions match the budget envelope for the HBP as a whole (which is a key concern to the Ministry of Finance).
3. Embedding the planning of revisions within the budget cycle and tools employed by the Ministry of Finance for programming and managing of funds (e.g., risk registry, spending reviews, etc.) can foster collaboration between the two agencies.

Chapter 8: Conclusion

Explicit and evidence-based HBPs are a vital tool for countries striving to achieve UHC. They should be regularly revised to suit evolving health needs such as changing disease burdens, fluctuating budgets, and the emergence of new services and health technologies; to address implementation challenges; and to ensure that the package is up-to-date and that available resources are used efficiently and wisely and provide the best possible value for money.

This report presents guidance on health benefit package revision, building on a three-year engagement with technical staff and decision makers from 14 countries as well as a review of the literature (adding case studies from four more countries). It is the first resource that provides practical guidance that can be adapted to each country's characteristics. It starts with identifying five key principles: HBP revisions are an evolutionary process; aim for universal coverage of existing priority services before expanding the package; disinvest from low-value services; ensure the revisions to the package are costed, within budget, and appropriately resourced; institutionalize periodic revisions to help stay on the path to UHC.

There is no single right approach, so we encourage countries to learn from other countries with a similar decision-making context and to engage in networking. Global networks such as the JLN¹²⁶, iDSI¹²⁷, and regional ones, such as RED CRITERIA¹²⁸, RedETSA¹²⁹, and HTAsiaLink¹³⁰, provide that opportunity and form platforms for further specific-country collaboration on HBP revision. In addition, we hope that this guidance provides a basis for other researchers and analysts to produce more extensive guidance to support the implementation of HBP revisions, such as changes in provider payment arrangements or human resources planning.

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Appendix I: The JLN Efficiency Collaborative members survey

Background information

- What country do you work in?
- What is your name?
- What division do you work in and what is your job title?
- Can you tell us what you work on a day to day basis? (check all that apply)
 - Health financing reforms / strategy
 - UHC implementation
 - Health Technology Assessment / priority setting
 - Pricing, product selection, or procurement more widely
 - Planning, budgeting, resource allocation
 - Relationships with donors and external partners
 - COVID-19 planning
 - Research
 - Other:

All participants

1. Does your country have an existing health benefits package (HBP) or is it in the process of developing one?
 - a. Yes
 - b. No
2. Is this HBP funded through a mechanism of pooled resources (e.g., tax revenues, premiums, etc.)? (planned or existing)
 - a. Yes
 - b. No
3. Are there dedicated funding lines to reimburse providers or pay decentralised authorities for the delivery of the HBP? (planned or existing)
 - a. Yes
 - b. No
4. Is there any legislation that guarantees to citizens the entitlements specified under the HBP? (planned or existing)
 - a. Yes
 - b. No

If you answered Yes to any questions 2–4, then we will consider this to be an implemented HBP. If you answered No to all, then we will consider this to be an aspirational HBP.

5. Based on the three questions above, do you have an implemented HBP?
 - a. Yes
 - b. No

Countries that do have an implemented HBP

6. What is the name of the HBP or UHC scheme? What year was it implemented?
7. What stage of implementation is this HBP at?
 - a. HBP is in the process of being developed
 - b. HBP has been developed, but implementation is underway
 - c. HBP implementation has been initiated but is still ongoing
 - d. HBP is fully implemented and has been running for 1+ year
8. Can you describe in a few lines: (i) how the HBP was developed? (ii) what objectives it intended to fulfil? (iii) approximately how long it took to be developed?
9. What were, at the time, the positive and negative lessons about developing this HBP? If you could have done it differently, what would you have changed?
10. According to you, what are the three biggest challenges facing your country when it comes to HBP (and that you would like to work on with us?)
 - a. HBP is too narrow
 - b. HBP is too generous and needs to be downsized
 - c. HBP includes too many high-cost interventions
 - d. Package is out of date and needs to be reviewed
 - e. The human resources and infrastructure required to deliver the package are not sufficient

- f. Utilization rates are still very low
- g. The financial resources required to deliver the package are not sufficient
- h. HBP entitlements are not well defined and too broad
- i. HBP entitlements are debated strongly by stakeholders (e.g., within ministry, patient groups, and the public), and there is low approval or acceptance
- j. Other:

11. Has the HBP been revised since it was first developed?

Countries that do have an implemented HBP and have undergone a revision

12. What were the primary reasons for this revision? How was the need for a revision identified?

13. Please describe what the revisions consisted of: Year(s) of revision and revision description

14. As part of the revision processes described above, did you

- a. Add to the list of entitlements
- b. Refine the way some of the existing entitlements were specified (e.g., to account for health innovations in the practice of care)
- c. Remove entitlements

If you could provide any supplemental information on the actions performed during the revisions, please specify:

15. Can you describe, in a few words, how the process of revision was organised? Who was in charge? How long did it take? How were areas of revisions identified? Detail any evidence-based approaches that were used.

16. Are there any legal provisions or policies in place to plan for periodic HBP revisions in your country?

17. What type of good practice could you share with our collaborative about your experience of revising the HBP? (e.g., building an inclusive and transparent process, use of data and evidence, public consultation, plans to improve financial sustainability)

Countries that do have an implemented HBP and have not undergone a revision

12. How has the HBP evolved since its first definition (if at all)? For example, has it gone through adjustments (in other words, small additions to or removals from entitlements) at the margin?

13. Have you ever undertaken any attempts to conduct revisions that were not successful? If so, what do you think were the main challenges to revisions?

14. Are you planning a revision? If yes, then when?

15. Can you describe in a few words how other members of the EC or this knowledge product could support this revision process?

Countries that do not have an implemented HBP

6. Is your country currently developing or planning to develop an HBP? If yes, please explain.

7. What are the main challenges that you anticipate in the creation of an HBP? (check all that apply)

- a. Lack of funds to establish a UHC scheme/HBP and/or concerns about sustainable financing to maintain one
- b. Insufficient capacity to deliver the package (e.g., infrastructure, adequate health workforce)
- c. Concerns about the current quality of care
- d. Political will
- e. Political economy challenges
- f. Lack of guidance and consensus in the country on how to prioritize entitlements
- g. Other:

8. This knowledge product is intended to inform how revisions on HBP may be undertaken. Can you explain, within this topic, what your particular areas of interest may be?

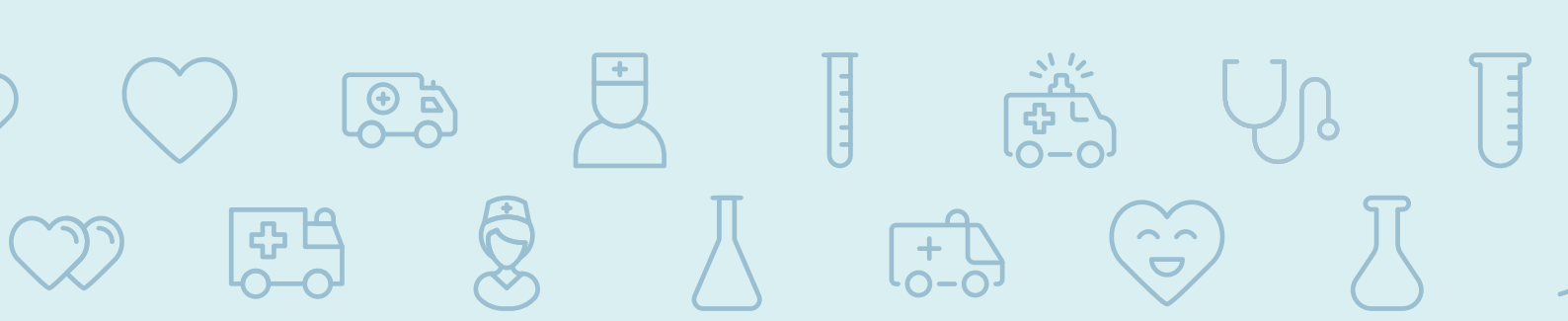
Many thanks for answering this survey. We are planning events and country outreach calls on HBP revisions. Are there any experiences from your country that you may wish to share with us?

Appendix 2: Survey responses

Country	Number of responses
Bangladesh	2
Ethiopia	1
Ghana	4
India	1
Indonesia	3
Kenya	1
Laos	1
Malaysia	1
Mongolia	2
Nigeria	1
Philippines	2
South Africa	0
Sudan	1
Vietnam	0

Appendix 3: Country examples included in this report

	EC Country	Non-EC Countries (informed through the literature)
	Bangladesh, Ethiopia, Ghana, India, Indonesia, Kenya, Laos, Malaysia, Mongolia, Nigeria, Philippines, South Africa, Sudan, Vietnam	Chile, Iran, Pakistan, Thailand
TOTAL	14	4
		18



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