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USING EVIDENCE TO DESIGN HEALTH BENEFIT PLANS FOR STRONGER HEALTH SYSTEMS: LESSONS FROM 25 COUNTRIES



June 2015

This publication was produced for review by the United States Agency for International Development. It was prepared by Sharon Nakhimovsky, Lauren Peterson, Jeanna Holtz, Catherine Connor, Sinit Mehtsun, Amanda Folsom, and Laurel Hatt for the Health Finance and Governance Project.

The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manages those precious resources more effectively, and makes wise purchasing decisions. As a result, this five-year, \$209 million global project increases the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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ACRONYMS

AUGE	Universal Access with Explicit Guarantees (Chile)
CAUSES	Universal List of Essential Health Services (Mexico)
CBHI	Community-Based Health Insurance
CEA	Cost-Effectiveness Analysis
EPCMD	Ending Preventable Child and Maternal Deaths
HBP	Health Benefit Plan
HSA	Health Systems Assessment
HTA	Health Technology Assessment
JLN	Joint Learning Network
LMIC	Low- and Middle-Income Countries
OOP	Out-of-Pocket
PBS	Basic Health Package (Honduras)
PIAS	Comprehensive Health Plan (Uruguay)
POS	Compulsory Health Plan (Colombia)
RSBY	Rashtriya Swasthya Bima Yojana (India)
SHI	Social Health Insurance
SIS	Comprehensive Health Insurance (Peru)
UHC	Universal Health Coverage
UNICO	Universal Health Coverage Studies Series
USAID	United States Agency for International Development
WHO	World Health Organization
WHO-CHOICE	World Health Organization CHOosing Interventions that are Cost-Effective Project

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EXECUTIVE SUMMARY

Low- and middle-income country governments face competing health priorities as they try to increase their populations' access to affordable healthcare with limited resources. Faced with difficult choices, how can governments align their spending with health system objectives? One common policy instrument governments are using is the health benefit plan (HBP), defined here as a pre-determined, publicly managed list of guaranteed health services. Based on country experiences, the authors of this report argue that using evidence improves the potential for HBPs to achieve and balance countries' objectives for equity, efficiency, financial protection, and sustainability in the health sector.

Governments using—or considering—HBPs as part of their pathway to UHC are faced with complex questions as they prepare to design new HBPs or update existing ones to address technological, epidemiological, economic, or other changes. This report is intended to serve as a resource for these governments. Through a review of 25 countries examining the types of evidence used to design and update HBPs, this report identifies actionable lessons for designing HBPs that advance health systems objectives in a sustainable way.

How has evidence improved the role HBPs play in increasing a populations' access to affordable health services? HBP is a policy instrument for explicit priority setting, an approach to resource allocation increasingly used by governments globally. This report discusses the types of evidence both designers and implementers of health policy can use to make the HBP a catalyst for advancing the UHC objectives of improved equity, financial protection, and efficiency.

- **Equity:** Some governments have used disease burden data to measure differences in health status across populations, utilization data to assess differences in access, and household surveys to evaluate health expenditure. Others have balanced higher cost investments targeting men with those targeting women to promote gender equity.
- **Efficiency:** Governments use cost effectiveness analysis (CEA) data to increase funding spent on high-impact, low-cost services. They use unit costs of services at different types of facilities to identify more cost-effective providers, consequently reducing the costs associated with providing services. To date, use of CEA data is more common in higher-income countries and lower-income countries receiving external support. Governments are encouraged to adapt global and regional cost-effectiveness ratio estimates to local contexts as part of their evidence base.
- **Financial Protection:** Data on household out-of-pocket (OOP) spending as a percentage of total health spending can inspire political action, while out-of-pocket spending by service and population groups can illustrate gaps in financial planning and inform the process of selecting services to include in the HBP. In addition, data on forgone care due to inability to pay are essential for understanding financial barriers not captured in OOP spending data.

Can using evidence help to promote the sustainability of an HBP? A sustainable HBP will contribute to progress towards UHC over the long-term. This report discusses the role of evidence in the following areas of sustainability: financial sustainability (making plans for long-term financial viability), program adaptation (adapting policies to ensure continued relevance and effectiveness), and political sustainability—both by leveraging stakeholders and engaging in public discourse.

- **Financial Sustainability:** Designing an overly generous HBP that is unaffordable—either due to lack of or disregard for evidence on cost— can overburden the health system, erode political and public support, and weaken the fiscal strength of the government. This review shows that few governments have sufficient information on projected budget and cost information and are now addressing critical sustainability challenges.
- **Program Adaptation:** HBPs must be updated routinely to account for new—often expensive— technologies, as well as population health needs. Adapting HBPs to changing contexts is best done according to institutionalized processes that include protocols for using evidence; several higher-income governments in the sample are currently working to establish these processes. Pilot testing and monitoring data are also good sources for updating HBPs; governments should strive to establish monitoring protocols, separately or as part of existing systems, from the initiation of the HBP.
- **Political Sustainability:** Sustainability requires that key stakeholder groups—including providers, government officials, technocrats, and the public— consider the HBP a legitimately established and maintained policy. Stakeholder engagement is important to both the process of updating an HBP and designing one, though many governments’ experiences show that these processes often lag after the initial design phase. A growing number of governments are engaging the public in dialogue on HBP design and routine implementation through methods including gathering and using surveys or focus groups on social preference. The experiences detailed in this report show that efforts to reflect public demand in HBP policy and communicate the process and benefits of the policy, may pay off both financially and politically.

What actions can stakeholders take to create more evidence-based HBPs? The report highlights emerging lessons relevant for all countries regardless of available resources or the maturity of their HBP, including the following key messages:

1. Whatever you do, document it! There has been limited documentation of HBP design and update processes in the countries included in the report sample. Transparently defining and managing services explicitly included and excluded from the HBP can help to reduce costs and maintain legitimacy in the long run. Governments can benefit from mapping out a plan, prioritizing evidence needs, and planning for generating evidence in advance. Preserving data used in prioritization processes also benefits other countries grappling with HBP design, as well as future decision makers.
2. Use of evidence doesn’t have to slow you down. Using evidence does not necessarily mean analysis paralysis. LMIC governments interested in HBPs but lacking sufficient evidence should move forward cautiously while gradually improving their supply of evidence and capacity to translate it. After taking stock of available local evidence, governments can consider using global guidance documents and estimates to fill gaps, prioritize short- and long-term investments in evidence generation, and communicate unfunded evidence needs to development partners. In designing HBPs, governments can also create room for adjustments by expanding the number of benefits to the population gradually. Alternatively, governments can consider using other types of policy instruments for explicit priority setting that require less extensive evidence to buy time

for generating the evidence needed for an HBP – for example, negative lists, which list the services that will not be provided under public schemes; or financial benefit packages, which provide a level of monetary benefit, regardless of the covered services obtained.

3. Plan for generating and using evidence within a larger context of stakeholder engagement. When technocrats are isolated from other stakeholders in the design process, their evidence-based solutions can only be accepted or rejected. Creating processes that facilitate continual exchange between technocrats and other stakeholders allows for discussion of stakeholders concerns while still drawing upon evidence to inform design. Integrating technocrats into the stakeholder engagement process can also ensure that other stakeholders apply the evidence technocrats generate, and in turn, that technocrats generate the evidence needed by stakeholders. Champions can play an important role in promoting the initial use of evidence in HBP design and institutionalizing protocols for using evidence in HBP updating.
4. Donors can help. Donors can play a role in the both the HBP design and update processes. Specifically, donors can support LMIC governments in strengthening priority-setting institutions for HBPs by investing in systematic reviews and global and regional estimates of needed evidence (e.g. unit cost data), as well as other guidance documents that can be adapted to local settings. External partners can also help build capacity to translate such research and guidance into relevant material to support prioritization processes.

I. INTRODUCTION

Through a review of 25 governments' experiences, this report shares actionable lessons that LMIC governments engaged in HBP design or updates can consider in order to get the most out of their HBP. The report considers questions about the role of evidence in HBP policy development in sample countries and factors that facilitated or inhibited evidence-based discussion and action.

I.1 The Case for Using Evidence in Developing Health Benefit Plan Policy

Governments seek to advance towards universal health coverage but also face resource constraints. Universal health coverage (UHC) is the idea that all people should have access to the quality health services they need, without risk of financial hardship [2]. While demand for health care may be infinite, countries' resources to satisfy this demand are not [3]. This challenge is intensified by the rapid development of new, often expensive health care technologies that may improve health outcomes but can also fuel a rise in health spending. As a result, governments face many tradeoffs as they not only consider population and service coverage but also other key criteria, including efficiency, equity, financial protection, and sustainability. How can governments pursue UHC objectives given resource constraints?

Many governments are turning to health benefit plans (HBPs)—a policy instrument for explicit priority setting—to improve equity, access to services, and financial protection, and also establish legitimacy for their decisions.¹ Explicit priority setting allows governments to transparently specify decisions about what services and populations to cover (among other resource allocation decisions) before commitments are made (Figure 1)[3]. Glassman and Chalkidou (2012) note that when benefits are not explicitly defined, resource allocation occurs implicitly by limiting “the quantity of services provided after a decision is made to make these services available” [3].

Implicit resource allocation can occur through mechanisms such as time (first come, first served), price (allocate resources to those willing to pay higher prices), and distance (allocate resources to those with easiest geographic access)[3]. Using these implicit mechanisms as the sole basis for allocating public health funding can result in an inequitable and inefficient distribution of resources, thus leading many countries to find explicit options, such as HBPs, appealing.

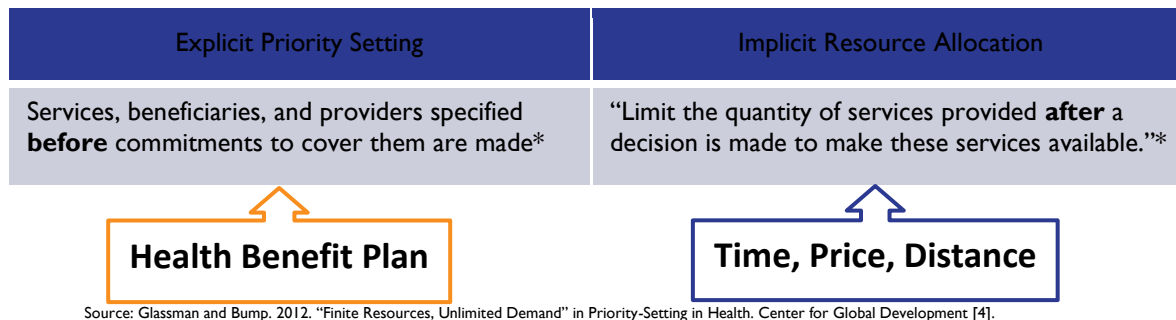
In this report, an HBP is defined as a publicly managed list of guaranteed health services, accessed at approved health care providers by specified populations, with pre-established levels of financial support for beneficiaries.

Adapted from: Giedion et al. 2014

¹ As of 2012, 64 LMICs have chosen to use HBPs (Glassman and Chalkidou, 2012) and 80 percent of 22 countries covered in the World Bank UHC “UNICO” Studies Series use HBP as part of their UHC strategy (Glassman and Chalkidou, 2012; Giedion et al., 2014). (See UNICO Studies Series at <http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>.)



Figure I. Two Ways to Cope with Resource Constraints through Priority Setting



Source: Glassman and Bump. 2012. “Finite Resources, Unlimited Demand” in Priority-Setting in Health. Center for Global Development [4].

The more evidence-based HBPs become, the more they will advance governments UHC objectives. Though this statement has not—and cannot—be proven, there are several strong arguments for using evidence in HBP design, including the following:

- Without using evidence, the desire to improve equity, access, and financial protection may remain theoretical and unattainable rather than practical. Evidence can move policymakers from rhetoric to action, translating bold statements on the need to improve health outcomes to real policy solutions. For example, comparing cost-effectiveness of interventions that respond to a similar health need, and selecting those with greater value for money, will produce an HBP that improves efficiency in health spending—ultimately saving more lives for the same investment. Similarly, comparing average cost per patient of a service at different facilities and selecting the less expensive HBP provider, can also make HBP a vehicle for improving efficiency.
- The alternatives to using evidence include relying on historical precedent and the preferences of key stakeholders who may be motivated by political, economic, or personal factors. Although using such alternatives may be easier than using evidence, they will not likely result in HBP policy that embodies an effective and efficient way of fulfilling the population’s health needs within budget constraints.
- Stakeholders to the HBP design and update process include those with a national, health systems-wide perspective as well as those focused on specific conditions or health services (e.g. specialists, vertical programs, industry, and non-governmental organizations). A design and update process that has a strong role for evidence can allow decision-makers to leverage both broader systems-level and disease- or technology-specific data contributions in a systematic way.
- As an explicit priority setting policy instrument, HBPs are fundamentally about transparency. Evidence provides a rational justification for decisions that can be more easily communicated to stakeholders. Using transparent, systematic processes to review evidence and soliciting input from key stakeholders can strengthen the legitimacy of the HBP.

Lessons based on this review for LMIC governments engaged in HBP policy development include:

- Whatever you do, document it! There has been limited documentation of HBP design and update processes in the countries included in the report sample. Transparently defining and managing services explicitly included and excluded from the HBP can help to reduce costs and maintain legitimacy in the long run. Governments can benefit from mapping out a plan, prioritizing evidence needs, and planning for generating evidence in advance. Preserving data used in prioritization processes also benefits other countries grappling with HBP design, as well as future decision makers.

- Use of evidence doesn't have to slow you down. Using evidence does not necessarily mean analysis paralysis. LMIC governments interested in HBPs but lacking sufficient evidence should move forward cautiously while gradually improving their supply of evidence and capacity to translate it. After taking stock of available local evidence, governments can consider using global guidance documents and estimates to fill gaps, prioritize short- and long-term investments in evidence generation, and communicate unfunded evidence needs to development partners. In designing HBPs, governments can also create room for adjustments by expanding the number of benefits to the population gradually. Alternatively, governments can consider using other types of policy instruments for explicit priority setting that require less extensive evidence to buy time for generating the evidence needed for an HBP – for example, negative lists, which list the services that will not be provided under public schemes; or financial benefit packages, which provide a level of monetary benefit, regardless of the covered services obtained.

Local context matters a great deal in priority setting of any kind as the process is “inevitably value-laden and political” [1]. Therefore, the “**lessons**” identified in this report are not recommendations but rather points that governments can consider as they design and update their HBPs. The global approach taken in this report has the benefit of considering and synthesizing many experiences relevant to LMICs seeking to advance their understanding of HBP design and update. Readers are encouraged to translate these lessons to their local context.

- Plan for generating and using evidence within a larger context of stakeholder engagement. When technocrats are isolated from other stakeholders in the design process, their evidence-based solutions can only be accepted or rejected. Creating processes that facilitate continual exchange between technocrats and other stakeholders allows for discussion of stakeholders concerns while still drawing upon evidence to inform design. Integrating technocrats into the stakeholder engagement process can also ensure that other stakeholders apply the evidence technocrats generate, and in turn, that technocrats generate the evidence needed by stakeholders. Champions can play an important role in promoting the initial use of evidence in HBP design and institutionalizing protocols for using evidence in HBP updating.
- Donors can help. Donors can play a role in the both the HBP design and update processes. Specifically, donors can support LMIC governments in strengthening priority-setting institutions for HBPs by investing in systematic reviews and global and regional estimates of needed evidence (e.g. unit cost data), as well as other guidance documents that can be adapted to local settings. External partners can also help build capacity to translate such research and guidance into relevant material to support prioritization processes.

1.2 Rationale, Audience, and Organization of the Report

Rationale: Governments with HBPs are facing important challenges in designing, managing, and updating HBPs, particularly in light of fiscal sustainability concerns. Given these challenges, there is increasing interest in improving processes for designing and updating HBPs by learning from other governments' experiences [5]. The global health community has also called for more sharing of experiences in priority setting that are relevant for developing countries [1].

The authors reviewed the experiences of 25 countries to draw practical and actionable lessons relevant for LMIC governments interested in embarking on or improving HBP reform. The experiences reviewed come from upper–middle-income countries further along in HBP development as well as lower-income countries just starting such reforms. They also represent many regions including Asia, Africa, and South

America (see Annex I for selection methods). Despite limited documentation of the processes used to apply evidence during HBP design in some of the countries reviewed, the diversity in backgrounds and developmental stages allowed the authors to observe what worked and did not work in many contexts, and to compile this information in an accessible way for policy-makers designing and implementing HBPs to leverage past experiences from other countries.

Audience: This report is for LMIC health system stakeholders involved in the consideration, design, or update of an HBP. Individuals championing the use of evidence in the process may find this report particularly useful. The lessons may be most relevant for government stakeholders grappling with the design or update process of an HBP, as many of the practical lessons included in this report are drawn from public policy analysis and interviews with current and former government officials involved in the design of HBPs. While government stakeholders are often held accountable for the design and maintenance of an HBP, a variety of stakeholders including health care professionals, medical associations, patient groups, industry representatives, donors, and the general public, have strong interests in—and in some cases, significant influence over—the HBP design process², and are also included in the audience of this report.

Organization of the Report: Sections two and three of the report seek to advance the discussion around the question, “How to progress towards UHC with HBPs?” Section two focuses on the types of evidence that can be used to support progress towards three health systems objectives in achieving UHC: equity, efficiency, and financial protection. For each objective, section two synthesizes relevant past experiences and identifies lessons for promoting the use of specific types of evidence for stronger health systems. Section three considers how governments have used evidence to promote the sustainability of their HBPs. The last two sections—four and five—discuss cross-cutting lessons in using evidence as part of HBP policymaking and offer final conclusions.

² Formulation draws upon Gilson (2012).

2. USING EVIDENCE IN HBP POLICY TO IMPROVE EQUITY, EFFICIENCY, AND FINANCIAL PROTECTION

Policy designers and implementers can improve the potential of an HBP to aid progress towards UHC goals by using evidence. Table 1 presents types of evidence relevant for improving UHC-related goals through HBP policy. Discussion follows on experiences of LMIC governments in using these types of evidence to promote UHC. From these experiences, the section articulates lessons for other governments engaged in HBP reform to improve their health systems.

Table 1. UHC Goals and Relevant Types of Evidence

UHC Goal	Scope	Relevant types of evidence
1. Equity	Equity in access, in financial protection, and in health outcomes	Disease burden data; utilization data; monitoring and evaluation data; cost-effectiveness data
2. Efficiency: more health for the money*	Allocative and technical efficiency	CEA data (including global guidance based on cost-effectiveness data); unit costs of services by facility; disease burden
3. Financial protection	Protection from financial hardship, or reduction in financial barriers to access	Household OOP spending (including household surveys, provider records, and Health Accounts); data on forgone care due to inability to pay

Source*: Adapted from WHO (2010a)

2.1 Equity

“Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity” [5]. This statement embodies the idea that equity is not an isolated objective but an integral part of any pathway to UHC. The idea of “equity” encompasses equity in access to health services, equity in bearing the financial burden for this access, and, ultimately, equity in health outcomes. Of course, there is no global barometer for what is fair or unfair; the specific rubric is necessarily locally determined based on cultural norms. This subsection considers the characteristics of equity that are likely to be shared across cultures and discusses the role that an evidence-informed HBP can play in improving equity in the health system.

What is equity? How can an HBP improve it?

Equity in UHC means equity in access, financing, and health outcomes. Equity in access to quality services delinks a person’s need for healthcare from their ability to pay, or any other attribute such as ethnicity, geographic location, education, or gender. Improving equity shifts the determinants of access away from these attributes and places them instead on need (including awareness of need) [6, 7]. Equity in financing assumes that no group should bear a greater burden for financing than another. Improving equity in financial protection is about realizing transfers of funding from the wealthier and healthier populations to the lower economic classes who often account for a larger share of the disease burden [6]. Improvements in the equity of access and financial protection can allow for improved equity in health outcomes.

HBPs are a way to improve equity in the selection of beneficiaries, services covered, and financing schemes. In selecting the beneficiary population, an equity-based HBP can target the poor or other underserved populations—such as women and children—by establishing an essential minimum for the entire population or through a plan specifically designed for the poor [8]. In selecting services covered, an equity-based HBP will include services most needed by the poor and other underserved populations. Finally, in the design of financing arrangements, an equity-based HBP will ensure that contributions are linked to ability to pay and access to services is linked to need. This requires wealthier populations to subsidize poorer populations through individual contributions, general tax revenue, or another mechanism.

What types of “evidence” enhance governments’ ability to use HBPs to improve equity?

Many types of evidence can be used to ensure that the HBP will promote equity for a specific population. For any given population, disease burden data can show differences in health status across groups and utilization data can show differences in access. Household surveys on topics such as household health expenditure by income quintile can answer to equity in the distribution of financial burden and inform decisions about fee waivers, premium subsidies, and other targeted financing. Ongoing monitoring and evaluation of the use of services included in the HBP can also provide key data on equity in access to services, and for updating the HBP in an evidence-based way.

Health Systems Assessments (HSAs) and strategic planning reveal how HBPs can address inequity. As governments consider health system reforms to improve equity they must answer several big picture questions about the role HBPs play in the health system overall. For example, will they begin by covering only low-income populations or establish a population-wide HBP? An HSA reveals the underlying causes of inequity and therefore how an HBP—along with beneficiary and financing decisions—can improve equity.

There is a strong argument for using CEA data as not only a way to improve efficiency, but also to improve equity. Choosing to fund more cost-effective interventions will save more lives for the same investment. For example, the human papillomavirus (HPV) vaccine is many times more cost-effective than HPV testing for younger women, [9]—as are other interventions that reduce risk rather than treat illness. More lives are saved and suffering averted for essentially the same amount of money by investing appropriately in the HPV vaccine. When funding is allocated primarily to less cost-effective interventions, “the few are saved at the expense of the many, without any justification or compelling rationale,” [3]. Because HBP is a relatively new intervention, researchers need to continue studying its cost-effectiveness as the product changes and as more evidence on its effectiveness is generated.

Using a systematic and transparent process allows stakeholders to assess the equity implications of HBP design decisions. Using transparent, deliberative processes in applying equity criteria allows for full consideration of ethical and equity implications of decisions—e.g. how to distribute a limited amount of antiretroviral drugs—and involvement of key stakeholders without undue influence of one underserved population [3]. Transparency in such decisions is as important as using evidence in HBP design and update.

What have governments' experiences been in selecting services for improved equity?

Chile prioritized services where differences in health status among population groups were large. Chile considered socio-economic and gender inequities in the creation of the Universal Access with Explicit Guarantees (AUGE) HBP by including variables measured by differences in disease burden across populations, and ranking diseases with higher levels of inequality [10]. Analysis of the original 56 conditions included in the HBP indicates that 25 conditions have significant differences in mortality and prevalence across socio-economic groups, with another seven between men and women [10].

Mexico balanced investment in men with investment in women to improve gender equity.

The Government of Mexico used a different approach to address gender equity in the selection of less cost-effective interventions for the HBP for *Seguro Popular*. For example, recognizing that the anti-retroviral treatment supported by a strong lobby mainly targeted the male population, the Mexican government also included coverage for cervical cancer treatment at all stages of the disease despite a range in cost-effectiveness. Screening for cervical cancer was also included in order to promote relatively cost-effective interventions and reduce the need for treatment in the future [11].

LESSONS FOR USING EVIDENCE TO IMPROVE EQUITY

- Consider the examples from Chile and Mexico in using evidence in HBP design to improve equity in service coverage across gender, socioeconomic status, or other attributes of importance to an individual country.
- Positioning the HBP within the health system to best promote equity is a larger, mostly locally driven discussion. Global consensus based on research and stakeholder discussion seems to be that beginning with population coverage—creating one financing pool, with equal benefits for all—has the most promise [12]. However, in many LMICs this will not be possible; they will need to prioritize defined populations for HBP coverage to improve equity.

2.2 Efficiency: More Health for the Money

Unlike the health system goals of improved health status and financial protection, improving efficiency is an intermediate goal—not good by itself but a means to a stronger health system and UHC. Efficiency is a measure of whether healthcare resources are used in a way that maximizes value for money [13]. Improved efficiency releases “resources that could be used to cover more people, more services and/or more costs,” [2]. The WHO estimates that low-income countries could annually save 12 to 24 percent of their total health spending by improving hospital or workforce efficiency [2]. This subsection discusses the role of an evidence-informed HBP in improving efficiency.

What is efficiency? How can an HBP improve it?

HBPs can improve “allocative” and “technical” efficiency. The efficiency of a health system can be improved in two ways: (1) by spending more money on goods and services that produce higher impact with lower investment (“allocative efficiency”); and (2) by reducing the costs associated with providing goods and services (“technical efficiency”) in both public and private facilities.

An HBP can improve both types of efficiency in a health system. To achieve allocative efficiency, designers can include more cost-effective services in the HBP and allocate considerable public funds to the plan. To achieve technical efficiency, the HBP can specify methods of service provision, service providers, treatment protocols, and products (e.g. generic drugs) that are less expensive than others.

The HBP can also be accompanied by specification of provider payment methods that incentivize efficiency with safeguards for quality and equity. To address technical inefficiencies such as corruption and fraud, the HBP can require that providers be accredited—or the accompanying financing system can incorporate ways to check on provider and supplier expenditures.

What types of “evidence” allow governments to use HBP to improve efficiency?

CEA data are an important source of evidence to improve allocative efficiency through an HBP. CEA data quantify the amount of health goods or services purchased per dollar investment. These data can determine which diseases and health areas are more cost-effective to target with public funding, and which mix of goods and services is cost-effective compared to others in targeting any give disease or health area, including the relative mix of preventive versus treatment interventions. CEA data are based in part on burden of disease data, and are thus closely connected to need for services [14].

Unit costs of services at different types of facilities are an important source of evidence to identify more cost-effective service provision methods and providers for improved technical efficiency. Unit costs measure the total costs for delivering a service per patient or other relevant unit (e.g. diagnosis). These costs include “fixed costs” that remain constant regardless of the number of services provided (e.g. rent and electricity) and “variable costs” that vary with the number of services provided (e.g. syringes and other medical supplies). Fixed and variable costs may be very different depending on the type of provider. With information on which type of facility can provide which services at what cost—given a certain level of quality—the HBP can designate specific providers for selected services. In addition to unit costs, some CEA data measure technical efficiency, for example, which combination of inputs will improve a health outcome for the least investment.

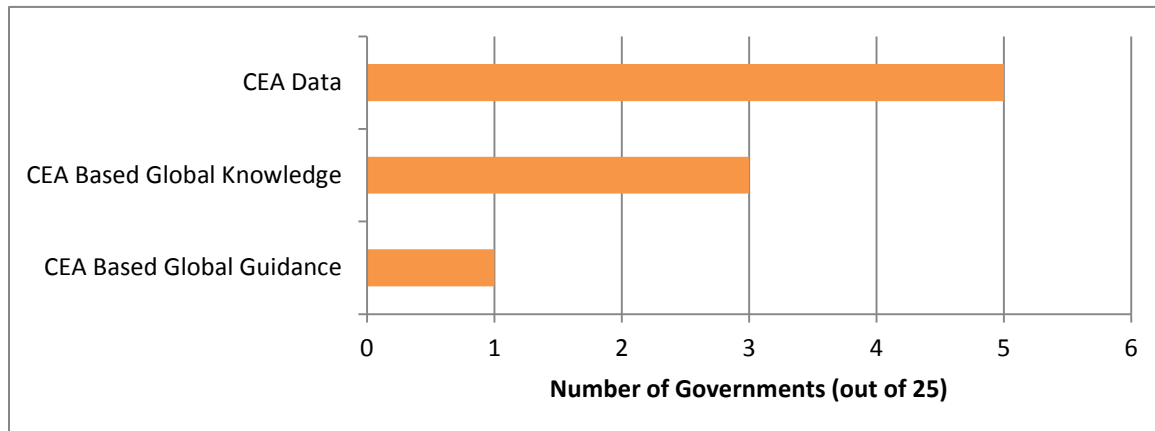
HBP compare CEA data and unit costs to a benchmark or to each other. When a benchmark is used, any health service that costs more than this benchmark per unit of health would not be funded. When used as relative values, designers can rank goods and services by their relative cost-effectiveness, creating explicit opportunities to spend more on high-impact, low-cost interventions. Unit costs are also typically used in comparison with each other—for example, comparing across different levels of facilities (e.g. hospital versus health centers) or in different sectors (public hospitals versus private hospitals).

Decision-makers should not necessarily use efficiency as the sole criterion to rank interventions. HBP designers and the people they are designing for have other important objectives to consider such as equity, quality, financial protection, responsiveness, and sustainability. Designers can optimize a selection that is strongly influenced but not perfectly aligned with cost-effectiveness ranking. Other criteria, such as equity, can also be included when quantifying impact per cost.

What have governments’ experiences been so far?

Nine of 25 governments used CEA data in HBP design to improve allocative efficiency. As Figure 2 shows, five governments used detailed CEA data as described above. Other governments focused the HBP on health areas that have been shown in global literature to be cost-effective, such as maternal and child health and primary care. In deciding which drugs to cover, one government—the Philippine Health Insurance Corporation (PhilHealth)—utilized the WHO guidelines, “Package for Essential NCDs Disease Interventions for Primary Health Care in Low-Resource Settings” (PEN) (WHO Guidelines) [15].

Figure 2. Use of Cost Effectiveness Data³



These examples show that use of CEA data varies with national income, and use in lower-income countries occurred alongside donor support. Of the countries in Figure 2 that used CEA data in designing their HBPs, one was high-income and the others were upper-middle income. The low- and lower-middle-income countries noted in Figure 2 relied on CEA-based global knowledge and guidance and also received external support in the HBP design process.

Several governments used evidence to select lower cost inputs for services delivered through the HBP, improving technical efficiency in the health system. In China's Zhuhai municipality, the government observed that average cost per patient for services at community health centers was 40 percent less than the amount for patients at hospitals. The government used this comparison in the design of its chronic disease specific HBP, which requires first contact with the health system to happen at community centers [16].

Comparing average cost per patient to select providers is not always possible. As the developers of Mexico's *Seguro Popular* discovered, sometimes more costly service providers are also key stakeholders in the HBP. An interviewee for this report indicated that to make *Seguro Popular* succeed as a policy instrument, the Mexican government needed to be inclusive of these providers [11]. The government was still able to make *Seguro Popular* a vehicle for improving efficiency, using CEA data in selecting services provided.[11].

LESSONS FOR USING EVIDENCE TO IMPROVE EFFICIENCY:

- Take advantage of global and regional CEA estimates and customize them to the local context. Begin with the Disease Control and Prevention Project 2 [14] and the WHO-CHOICE materials.⁴ Other global and regional organizations working to support use of CEA and explicit priority setting can be found in Appendix C of Glassman and Chalkidou (2012).
- There are many other types of technical inefficiencies that HBPs can address, such as irrational use of drugs or inappropriate hospital size, admissions, or length of stay. To identify, understand, and address each source of inefficiency, stakeholders may need to utilize a different type of evidence [17].⁵

³ Caveat: these are *documented* cases identified through a literature review. The methods used for this study are unlikely to have captured all actual uses of CEA data and other CEA-based evidence.

⁴ WHO-CHOICE materials can be located at: <http://www.who.int/choice/en/>.

⁵ See Chisholm and Evans (2010) for more on the major types of technical inefficiencies and the types of information that can be used to evaluate the extent to which they may be present in an individual country.

- What appears to be more cost-effective on paper may not be more cost-effective in practice, if estimates assume a higher level of capacity to deliver services than actually exists [14]. Capacity assessments are essential to fully understanding cost-effectiveness as well as optimal HBP design. Accurately gauging capacity to verify choices based on CEA estimates is an essential step to include in the design phase of HBP policy development.

2.3 Financial Protection

Financial protection is about protecting families from financial hardship such as catastrophic health expenditures when illness or accident requires expensive treatment. At the most basic level, an HBP improves financial protection by replacing household OOP spending—paid at the time of illness for doctor visits, medicines, lab tests, hospital stays, etc.—to “prepayment,” where payments such as premiums or tax contributions are paid independently of need for health services. An HBP can also reduce financial barriers to access for poor and vulnerable households who may be deterred from accessing care due to perceived inability to pay.

What types of “evidence” allow governments to use HBP to improve financial protection and reduce financial barriers to access?

Information on household OOP spending and forgone care due to inability to pay are key data sources. OOP spending data can be gathered through household surveys or provider records, and are synthesized with other health spending data in Health Accounts. More detailed OOP expenditure data will show which population groups—socio-economic, gender, regional—are most vulnerable to catastrophic expenditures. Many household surveys have questions on health expenditure.⁶ Health Accounts is a good source for accessing OOP expenditure data broken down by provider and service, among other dimensions.⁷

It is important to note that higher-income households may be more at risk of catastrophic spending than poorer households, with poorer households underutilizing services they need rather than facing impenetrable financial barriers [18]. Household surveys that ask about foregone care can capture this aspect of financial need.

Data on financial protection help identify the services that require subsidy in order to ensure that poor households are not barred from access due to financial constraints, or do not face financial ruin after accessing them. Tracking this type of information over time can show the impact of the HBP on financial protection. With a ranking of services requiring subsidy for poor households, designers will then need to balance the desire to provide financial protection to beneficiaries with other criteria such as cost-effectiveness and sustainability.

⁶ The Demographic and Health Survey (DHS) includes an optional expenditure module, available upon request for the current phase of the survey (2013-2018): www.dhsprogram.com/What-We-Do/Survey-Types/DHS-Questionnaires.cfm.

⁷Health Accounts is an internationally standardized methodology for tracking the flow of health spending through the health system, and is used in over 130 countries globally. For more information, please see the WHO’s resources on Health Accounts: www.who.int/health-accounts/en/

How have governments balanced their interest in improving financial protection with other criteria such as improved equity and efficiency?

UHC objectives are to improve equity in access to services as well as protection from financial risk. To increase access to more services for more people for a given amount of money requires prioritizing cost-effectiveness data [2]. How have governments faced the necessary trade-off?

Some governments established an HBP focused on providing financial protection. The Government of Kenya founded the National Hospital Insurance Fund (NHIF) in the 1960s in order to protect beneficiaries from the financial burden of hospital costs and use funding from healthier, wealthier beneficiaries to subsidize the needs of the sick and the poor [19]. India's RSBY provides a different rationale for focusing on financial protection: the government wanted to move forward despite the limited evidence it had to prioritize inpatient services. To do so, it created a simple HBP largely based on financial coverage regardless of service purchased, targeting households below the poverty line. In India, RSBY has begun the process of protecting beneficiaries from the financial risk of high-cost services while also allowing time to generate additional evidence.

Other governments separate funding for the most cost-effective services and cap the budget for less cost-effective services. For example, the Governments of Uruguay and Mexico separate the prioritization of essential services (likely based to some extent on cost-effectiveness) from the prioritization process for high-cost services, with each having their own funding streams [20, 21].

LESSONS FOR USING EVIDENCE TO IMPROVE FINANCIAL PROTECTION:

- Putting a cap on funding for high-cost services can help ensure that essential services get their equal share.
- Include the expenditure module when conducting a Demographic and Health Survey—this can generate needed information on OOP spending.
- Use CEA evidence to defend hard choices about which services to extend financial protection and to negotiate provider payment reforms that contain costs.
- Health Accounts is a good investment not just for HBP design but also for other policy objectives as well. For more information, see the WHO website and the HFG brief on the policy applications of Health Accounts [22].



3. USING EVIDENCE TO PROMOTE THE SUSTAINABILITY OF THE HBP

Sustainability of a public health policy is “the ability to maintain programming and its benefits over time” [23]. The goal of sustainability for an HBP is to make it a relevant policy instrument contributing to progress towards UHC over the long-term. To promote sustainability of their HBPs, governments are exploring ways to build their capacity for maintaining an HBP’s viability and relevance. This section discusses the role evidence can play in making an HBP more sustainable and building sustainability capacity for HBP reform.

This study demonstrates opportunities for designers and implementers to improve sustainability of an HBP using evidence in three areas. Table 2 presents these four areas and the evidence governments in this study considered in their efforts to promote sustainability. The remainder of the section discusses each area of sustainability and relevant types of evidence in turn.

Table 2. Areas of Sustainability and Relevant Types of Evidence

Area of Sustainability	Definition	Relevant types of evidence
1. Financial sustainability	Making plans for long-term financial viability	Budgetary information projected over time; unit costs
2. Program adaptation	Adapting HBP to ensure continued relevance and effectiveness	Results from piloting; data from monitoring and evaluation; health technology assessments
3. Political sustainability – key stakeholders	Strategically engaging stakeholders in the use of evidence through institutions and processes	Experiences from other countries
4. Political sustainability - general public	Strategically engaging in public discourse on the design and outcomes of the policy	Population preference surveys; focus groups

Source: Adapted framework and definitions from Schell et al. 2013⁸

3.1 Financial Sustainability

Insufficient evidence during HBP design has limited the ability of governments to create an effective plan for long-term sustainability. Even middle- and upper-middle-income governments in the study sample—for example, Peru and Uruguay—lacked sufficient information on projected budget and cost information. These governments are now actively engaged in addressing HBP sustainability challenges [21, 24].

Some governments have used the iterative nature of HBP design to advocate for additional funding, with mixed results. In Mexico, the designers of *Seguro Popular* used a draft plan

⁸ The sustainability capacity framework comes from Schell et al. (2013). The concept definitions are adapted from their framework, with some changes relevant for HBP and the use of evidence in their design for the purposes of this paper.

which identified conditions that could and could not be funded with the current budget, to successfully advocate for additional government funding [11]. In contrast to this success, however, preparing an HBP that exceeds the budget can also backfire—Jenniskens et al. (2012) indicate that governments in Sub-Saharan Africa often propose HBPs that cost more than resources available [25]. In Uganda, the result of such a strategy was a loss of transparency and legitimacy—while the initial prioritization effort was evidence-based and transparent, the second was not [1].

LESSONS FOR USING EVIDENCE TO PROMOTE FINANCIAL SUSTAINABILITY

- Passing a bill that is unsustainable in the long-term—either due to lack of or disregard for evidence—carries tremendous dangers not only for the health system but for the fiscal strength of the government. Long-term budget and cost projections by service can be used to advocate for efficiency and protect against this result. Investing in preparing this evidence is a crucial stage in the HBP design process.
- Plan for many iterations of the HBP that are all equally transparent and evidence-based. It may be strategic for health stakeholders to use the HBP design process to advocate for additional funding, but plan for getting less. Ultimately, the less explicit the process that determines final decisions in the HBP design, the less the government will gain from the HBP as a policy instrument for explicit priority setting.
- If the choice appears to be between agreeing to an unsustainable HBP or nothing at all, consider other policy instruments—such as financial reimbursement plans—as a stepping stone to strengthen the HBP. See also section four, “make the most of the time and resources you have.”

3.2 Program Adaptation

HBPs must be updated routinely to account for new, often expensive, technologies as well as changing population health needs. Without routine, evidence-based updates, HBPs may become financially unsustainable and moreover lose their ability to support health systems objectives such as equity, access, and financial protection. Governments need to balance risk of paying for expensive new (sometimes unproven) technologies with the opportunity to treat a health condition more effectively. An HBP policy can guard against the first risk (expensive technologies) if it explicitly states what services are covered and there is a process for assessing new technologies and drugs. Updates are best completed according to processes that have legal backing and protocols for using evidence, such as Health Technology Assessments (HTAs).

Updating processes varied across the sample in frequency as well as the level of specificity and legality. Generally, governments with explicit HBPs organized by level of care and type of technology (e.g. Uruguay) tend to update service lists more frequently than governments with lists organized by health condition or disease (e.g. CAUSES in Mexico and AUGE in Chile). However, governments whose HBPs are organized by health condition or disease also tend to conduct a more comprehensive review of the entire HBP in addition to services offered, through implicit rationing at the time of each review.

Many governments with more mature HBPs are creating legal and institutional bases for evidence-based updates. The Government of Mexico recently introduced legislation that stipulates that the inclusion of any new technology must be accompanied by an economic evaluation demonstrating the technology’s advantages over already-included options [26]. Legislation is one of the

areas where most significant improvement is needed in most countries with mature HBPs (e.g. AUGE in Chile) [12, 26].

Pilot testing is used to identify and address process challenges in the rollout of a new health insurance scheme or other health reform. Pilots undertaken in various regions have also been used by governments such as those of Ethiopia—for their community based health insurance (CBHI) schemes—and Peru—for one of their HBPs known as the Essential Health Insurance Plan (PEAS)—to identify constraints in delivering guaranteed services or improve engagement of stakeholders and the public [11, 24]. Other governments, such as those of Chile and Argentina (*Plan Nacer* HBP), opted to implement the HBP for the whole population, gradually rolling out services that were covered and monitoring the reaction of the health system to the new reform.

Many LMIC governments have insufficient linkages between national health monitoring systems and monitoring systems or indicators specific to their HBPs. Currently, monitoring is often conducted on an ad-hoc basis during a review of an HBP or through a review of national health indicators that are not necessarily specific to the HBP [26]. There are notable exceptions:

- A government does not need to wait until an HBP is established to develop institutional monitoring. While RSBY is defined by financial benefits rather than an HBP, the Government of India has invested in a robust monitoring system with smartcard technology which RSBY now uses to track all transactions. These results are published publicly to improve transparency and make improvements to the scheme [15, 27].
- Among the more mature HBPs, Argentina’s *Plan Nacer* stands out as having one of the most advanced HBP-specific monitoring systems. The monitoring system serves as the basis for performance-based payments to Argentina’s provinces, and includes verification visits, a dashboard tool, and concurrent external audits [26]. The monitoring system has clear benefits for the HBP updating process, and its rigor has attracted funding from multiple external sources [28]. Other governments with more mature HBPs such as Uruguay and Chile are also beginning to develop systematic monitoring systems.

LESSONS FOR USING EVIDENCE IN PROGRAM ADAPTATION TO PROMOTE SUSTAINABILITY

- Formalize through law or regulation, an evidence-based process to update HBPs. These updates should be carried out frequently enough to keep pace with technological innovation—ensuring that new options are properly and transparently vetted before adoption.
- Piloting the HBP (gradual roll-out by region or service) can be an effective way of generating localized information to inform the design process.
- Don’t wait to invest in a monitoring and evaluation system. This investment will be valuable no matter the stage of HBP development. In fact it may be the most valuable in countries new to HBPs where it will create an important dataset for effective updates of the HBP.

3.3 Political Sustainability – Key Stakeholders

Integrating technical and political processes is the best way to ensure the successful passage of evidence-based HBP policy to legal implementation. Legitimacy of HBP policy will be stronger with the use of transparent, deliberative priority setting methodologies, an extensive consultation process with key stakeholders, and the disclosure of the process and details behind the HBP to the public [29]. A technocratic process involving the review, synthesis, and application of evidence according to defined protocols is at the foundation of evidence-based HBP policy-making.

Following through with both processes may not be enough. When technocrats are isolated from other stakeholders in the design process—as they are in many countries—their evidence-based solutions can only be accepted or rejected. Creating processes that facilitate continual exchange between technocrats and other stakeholders creates space for all stakeholders to inform the plan for design, the types of evidence used at each stage, and the decisions that flow from them. The use of an evidence-informed HBP is no longer a black-and-white issue but one that builds upon technocratic as well as political considerations.

This type of exchange is important throughout the design and updating of HBP policy. Integrating technocrats into the stakeholder engagement process allows technocrats to discuss evidence needs with stakeholders and for the two to prioritize the types of evidence they should generate in addition to the material already available. In some cases, technocrats can discuss the value of certain types of evidence to the HBP design process. In other cases, technocrats can gain insight on the types of evidence stakeholders and other policymakers would like to have, and align their work with these expectations. Both cases may facilitate use of evidence [30].⁹

A small but growing number of governments are integrating key stakeholders into HBP design and update processes. The Government of Chile strove to integrate these collaborative processes into the design of their HBP in the 2000s, and may be a model for HBP institutional design (Box 1). In another example, assessing new interventions in routine updates of Thailand’s Universal Coverage Scheme involves engagement with stakeholders (e.g. representatives from universities, industries, civil society, and patient groups) and the general public before submitting a recommendation to the technical committee [31]. In contrast, in Honduras, the government received the support of two skilled technical teams funded by external partners to develop an evidence-informed Basic Package of Services (PBS) HBP. However, the isolation of this technical group from other stakeholders and the public negatively affected the legitimacy of the HBP, subsequently impacting the practical value of the HBP as it is implemented [32].

Processes for stakeholder engagement often lag after the initial design phase. Most governments appoint a committee of technocrats and representatives of key stakeholder groups to design the HBP, but later formal engagement of key groups is limited. Key groups include medical practitioners, ministry of health representatives, and government economists. In Chile, a group of nine individuals—representing different organizations and fields of expertise—reviews and updates the AUGE HBP; but the process occurs behind closed doors and is not transparent [33].

Champions promoting use of evidence are important. Governments successful in developing evidence-informed HBPs often have a champion. A champion may not necessarily be a technical expert,

⁹ This is based on the framework of Lavis et al. 2006 where both “push” and “pull” approaches to generating and using evidence.

but someone who understands the importance of using technical material and can facilitate knowledge translation and exchange between technocratic and political actors. In some cases, the champion is a political leader. In an interview, the technical leader of RSBY suggested, “we will never know what might have happened [with RSBY in India] if not for Prime Minister Singh’s personal investment, or if implementation responsibility had been given to a different person” [34]. In other cases, a champion may be a health official. A review of health policy reform experiences in Bolivia, Cameroon, Mexico, and the Philippines found that “a strongly motivated senior health official” who championed evidence-informed concepts was essential in driving the policy process [20].

Losing such a champion can also alter the design of an HBP. For example, in the creation of the Compulsory Health Plan (POS), Colombia attempted to use explicit cost-effectiveness criteria with the support of renowned international technical experts. After the loss of one of its champions in a plane crash, these criteria were not applied in the design of the HBP, due to political considerations [11, 29].

LESSONS FOR USING STAKEHOLDER ENGAGEMENT AND EVIDENCE TO PROMOTE SUSTAINABILITY

- Create the right climate for using evidence for both the HBP design and update processes by integrating both technocratic and political processes, and institutionalizing the integrated processes through legislation [30].
- Technocrats and stakeholders can productively coexist; they can map out and prioritize evidence needs, and plan (including financial and technical resources) for generating evidence in advance during both the design and update process.
- For long-term impact, champions can strive to institutionalize processes for using evidence for legitimacy in the short-term and for continued evidence-based HBP policymaking in the long-term.
- It may be helpful to plan for integrating different stakeholders from the outset, using stakeholder and process mapping. This may help reduce reliance on individual champions for evidence use.

3.4 Political Sustainability – General Public

Exchanging information with the general public can strengthen the legitimacy and sustainability of HBP delivery and legitimacy. Such exchanges may include efforts to gather data from the public (e.g. through population preference surveys), engage in dialogue with them (e.g. through focus groups), or communicate messages to them. This section considers all three types of exchanges.

Reflecting population preferences in an HBP can garner public support—a factor in the politics of reform. Comparing the experiences of the governments of Colombia and Chile illustrates this finding. In Colombia, the medical association advocated that medical autonomy¹⁰ was protected by the constitution. Health care providers using this position to sway the media and public opinion successfully pressured the government to drop the HBP and instead adopt implicit rationing with a negative list (a list of excluded services)[29]. While the medical association in Chile used a similar

¹⁰ One of the main concerns about HBP as a policy instrument among healthcare professionals and medical associations pertains to adoption of care protocols. Giedion et al. (2014) use the definition created by medical providers in Chile to define medical autonomy: “the state’s obligation to fund any treatment prescribed to a patient, without restrictions, and without any concern for the resources that remain available to other patients”.

argument, the fate of the AUGE HBP was different. Why? Commentators argue that this opposition failed because of the strong support for the reform garnered from the public and political parties—in part due to the strong role that seeking and responding to population preferences played in the design of the HBP [26, 33] (see Box 1). This comparison shows that the ability of government or interest groups to draw public support can influence the successful passage of an evidence-based HBP.

While social preference survey data can be a powerful tool, its results may not always align with policy objectives. As the above example from Chile shows, population preference survey data can be a powerful tool in HBP policy reform. However, survey results may not align with the government’s vision for the HBP within UHC reform. In designing *Seguro Popular*, the Government of Mexico conducted surveys to understand the population’s preferences for services to include in the HBP. Survey results showed that the population was particularly interested in including high-cost hospital services in the HBP. This was in contrast to policymakers’ vision of the HBP as mainly increasing access to essential, cost-effective services. For this reason, the government ultimately did incorporate survey results into the HBP design process [11].

Bringing citizens directly into the design process can make the HBP better reflect citizens’ understanding of fair resource distribution and engender broad support. The Government of South Korea has found a way to involve citizens directly in the update of its national-level HBP. “Citizen Committees” review evidence on and prioritize the services short-listed by the HBP governing institution, which then considers the committees’ recommendations in its final decisions. Of note, 80 percent of participating citizens in the first round were willing to increase financial contributions of beneficiaries and decrease coverage of some services after they had completed the evidence-based review and considered aspects of decision-making such as cost-effectiveness and financing constraints [35]. Ultimately, nine of the 13 new services added to South Korea’s HBP during the first round were recommended by the Citizen Committees. Experts recommend increasing communication between participants and the rest of the population in order to make the process of designing and updating HBPs an even more powerful tool for transparency, communication, and ultimately, legitimacy [35].

Some governments are making an effort to engage in dialogue with the public as a routine part of HBP implementation. For example, in the Philippines, surveys funded by PhilHealth but implemented by a third party are conducted twice a year to gather information on public opinion. In communicating with the public, terms that resonate with the population, like “preventive care,” are used [15]. However, there remains insufficient engagement with the public on update of HBPs. In Peru, a lack of responsiveness to beneficiary demands combined with insufficient communication about the benefits covered by the PEAS HBP, exacerbated challenges with the rollout of the HBP. This caused the public to question the legitimacy of the processes for administering and updating the PEAS, undermining the potential of the HBP to expand access to services [24].

A clear communication strategy explaining key process issues and design decisions can reduce the potential for judicial challenges. Defending the exclusion of benefits from HBPs is one of the most significant challenges for countries with nascent or mature HBPs. A growing number of countries are facing legal challenges to HBPs from citizens demanding services not guaranteed in the HBP. Often these judicial challenges are for costly drugs for catastrophic illnesses like cancer. In Colombia, most of the legal challenges were for high-cost drugs—diverting up to 26 percent of the HBP contributory pool’s resources to cover services not included in the POS HBP [29]. Uruguay found that a communication strategy explaining key process issues and how benefits were selected reduced judicial challenges to the Comprehensive Health Care Plan HBP [21].

LESSONS FOR USING EVIDENCE TO PROMOTE SUSTAINABILITY THROUGH PUBLIC ENGAGEMENT

- Make a plan for clear communication about the design of the HBP and gathering feedback from the public at the beginning of the HBP design process. Active engagement and education of the public may pay off financially and politically.
- Gather social preference data as one of many approaches to public communication. As the experience of South Korea shows, involving citizens in the prioritization process can give decision-makers the opportunity to educate the public and respond to demand for services. However, given large differences in demand and policy objectives, using population preference data may not allow decision-makers to choose a strategic pathway to promoting UHC.
- Make engagement with the public a routine part of HBP implementation, not just part of the initial design phase. Use this as a way to continue the dialogue and ensure ongoing relevance and public support for the HBP.

Box 1: Paving the way for a sustainable and evidence-based HBP in Chile

Chile is known for having established an HBP (called AUGE) that—while imperfect—has a strong foundation in rigorous evidence and explicit processes. Factors enabling the evidence-informed design of the HBP in Chile (AUGE) lie in the institutional processes established, skilled leadership of champions, and deliberate use of population preference data.

In 2000, President Lagos put Dr. Sandoval in charge of the Health Reform Commission, a new inter-ministerial body tasked with designing Chile's health reform, including the drafting of AUGE. Committed to the use of evidence, Dr. Sandoval considered the 1990s Clinton health reform in the United States, learning from its advisors that the isolation of technocrats from other stakeholders may have played a role in its failure. Using this evidence, President Lagos and Dr. Sandoval created processes that sought to protect the technocratic nature of the legislation while also ensuring political engagement and institutional processes for resolving points of technical disagreement. The successful passage of AUGE as an evidence-based HBP also depended on skilled political leadership and broad popular support. From initial design to roll-out, President Lagos championed the reform as well as its technical and independent character through hurdles from opposition groups including the Chilean Medical Association and most of their political representatives, health service providers who felt threatened by the change, and Isapre (private insurance offering the AUGE HBP). President Lagos was aided by broad public support for AUGE—created in part through deliberate efforts to ensure that AUGE reflected public demand, through the generation and application of population preference data during the design process. This example shows that a reform design that effectively mirrored demand, may in turn have solidified popular support for its passage.

Source: Based on information presented by Escobar & Bitran (2014).

4. CROSS-CUTTING LESSONS ON USING EVIDENCE IN HBP REFORM

4.1 Whatever you do, document it!

Transparency is vital to a fair priority setting process [36], but there has been limited documentation of HBP design and update processes in sample countries. As others have stated before [1], it is critical to document and disseminate the process used for priority setting with HBPs. This information can be valuable to local stakeholders, future stakeholders, and other countries. This review has shown that literature detailing the role of evidence in the HBP design and update processes did not allow for the comprehensive assessment of all categories of evidence for all countries. Of the 25 countries in the sample, there are only eight HBPs with documentation on use of service costing data, and only four on use of feasibility/capacity assessments (Table 3); information on whether these types of evidence were used by other governments is not available. Similarly, information on criteria applied in the process of prioritizing services was not available for all HBP examples. This lack of information indicates insufficient documentation of processes.

Table 3. Results from the Literature Review

Type of Evidence	#HBPs using evidence in design process	#HBPs with no documentation
Burden of disease	15	10
Cost-effectiveness analysis	11	14
Feasibility/capacity assessments	4	21
Population preferences	5	20
Service costing data	8	17

Moreover, the documentation found in the review was largely conducted by global partners rather than the governments implementing the reforms. Governments may be missing a valuable opportunity to promote transparency in a rigorous way that can build legitimacy, contribute towards institutionalization, and provide meaningful information to other governments considering similar public health policies.

Be careful to preserve all previous data used in prioritization processes for future decision-makers. In Colombia, the original technical priority setting studies used to design the HBP were lost. In Uruguay and Mexico, researchers found insufficient evidence in public documents to cite in documenting the prioritization process in literature [20, 21, 29].

Seize more opportunities for sub-national comparison and shared learning. In decentralized priority setting contexts like China, there is potential for different municipalities and districts to learn from each other's experience. The team from the Government of Zhuhai municipality provided one helpful look into sub-national efforts to update HBPs [16]. However, there is insufficient documentation and communication of these experiences, as "mechanisms for cross-province data exchange are not yet in place" [37].

Greater transparency pays off. Formal complaints (e.g. lawsuits) and informal requests to cover excluded technologies can undermine the legitimacy of HBPs. They can also be very costly for governments. Transparently defining and managing services explicitly excluded from the HBP can help reduce costs and maintain legitimacy in the long-run. Similarly, clinical guidelines and clear definitions of medical autonomy from the outset can help control costs for HBPs defined by medical condition, particularly in cases where political interests may have diminished the use of evidence.

Map out and prioritize evidence needs and plan (including necessary financial and technical resources) for generating evidence in advance—for both design and update process.

Empower internal leaders to shepherd this effort by allowing them sufficient time to do so. When relevant, communicate with donors and development partners to identify needs that lack funding.

4.2 Make the most of the time and resources you have

HBP designers face institutional challenges—especially insufficient staff time and a short timeline for policy development, which can limit the quantity and quality of evidence available to decision-makers [38, 39].¹¹ As HBP design is often part of a larger health system reform, officials may be tasked with leading not only prioritization of services but also related aspects of design—such as logistics of enrollment or new provider payment mechanisms—or have responsibilities associated with the broader policy development effort. Capacity constraints are further exacerbated by short timelines, as key staff will have less time to devote to each task. Engaging stakeholders throughout the process is also more difficult when time is limited, a factor that may also impact the strength and legitimacy of the HBP.

Governments with a legacy of HBP policy development from past work have gradually strengthened HBPs through use of evidence over time. Examples of successful (albeit imperfect) HBP reforms (e.g. AUGE in Chile and CAUSES in Mexico) evolved over a period of many years as their governments increased their capacity to develop evidence-informed policies. Other governments (e.g. Ethiopia and Ghana) did not have this historical advantage while developing their most recent HBPs.

Facing resource, capacity, and time constraints, LMIC governments may want to implement an intermediate policy instrument to begin reform and buy time to gather more evidence for designing an HBP.¹² Giedion et al. (2014) demonstrates that HBPs can allow for greater potential in achieving health system objectives than other instruments such as negative lists, but at the same time require comparatively greater political and technical efforts to effectively create and pass into legislation [26]. Some governments with less ability to construct HBPs due to limited evidence, capacity, or time, have opted for negative lists (e.g. National Health Insurance Scheme—NHIS—in Ghana) or financial-reimbursement based packages (e.g. RSBY in India). Some of the governments that

¹¹ The health policy literature further explores the influence of other long-term factors on evidence-informed policies. For example, centralized systems with hierarchical management of evidence may limit the potential use of evidence (Liverani et al., 2013; Trostle, 1999). Countries developing policy in ad hoc, issue coalitions and/or characterized by strong governance emphasizing public accountability and transparent processes may have greater need for evidence to justify policy decisions (Liverani et al., 2013).

¹² It is important to note that these limitations are not the only reasons why governments might opt to use negative lists or financial-based plans. For example, as Giedion et al. (2014) indicate, the UK and Malaysia have the evidence and capacity to implement an HBP but opt for HTA within the context of implicit rationing as this instrument is better able to respond to changing conditions.

originally opted for less extensive health policy instruments are now moving towards developing an HBP. The intermediate introduction of these alternative instruments may allow technocrats to extend the timeline for generating the right evidence to back an HBP, while still maintaining political momentum for the reforms.

Alternatively, LMICs facing these constraints may want to develop an HBP without much evidence at the outset, and pilot test it in different regions in order to generate localized lessons learned needed to make adjustments and increase its effectiveness. Pilot tests of CBHI schemes in several regions allowed the Government of Ethiopia to address operational and enrollment challenges while also assessing the feasibility of delivering the HBP and evaluating use of health services by the target population. The Government of Ethiopia can use findings from the pilots to improve the CBHI schemes before scaling up nationally.

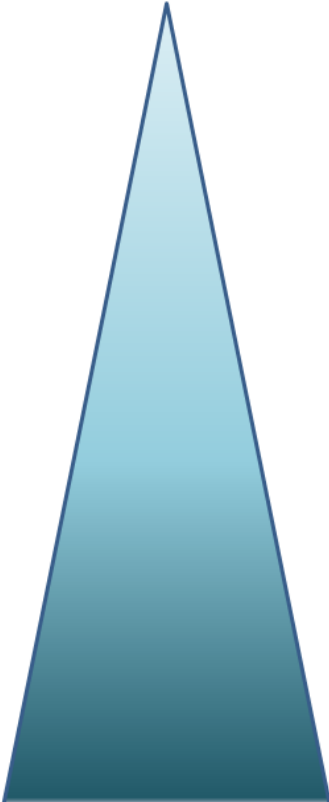
Ultimately, “perfect is the enemy of the good”¹³: Some governments have decided to wait to embark on HBP design until more of the needed evidence is gathered. Interviewees have recommended implementing intermediate policy instruments to buy for evidence generation, or piloting reforms in certain regions to inform HBP design. Both have tremendous promise for the long-term. Given that improving the evidence base, and creating a strong and sustainable HBP is a long-term endeavor, lack of evidence should not impede important work, but should move forward cautiously: lay the groundwork while also creating room to adjust policies through slow expansion of benefits.

¹³ Attributed to Voltaire who references an Italian proverb in [Dictionnaire philosophique](#) (1770).

4.3 How can donors help?

This research—with a sample crossing income groups —demonstrated the range in roles external partners, including donors, can play in the HBP design and update process. Figure 3 presents the types of activities external partners can support, organized by the strength of donor influence throughout the process—specifically in the generation, interpretation, and application of evidence. See Annex B for more details about each example.

Figure 3. Range in External Support in Evidence Generation, Interpretation, and Application in HBP Design and Update

Level of Support	Example Actions by External Partners	Governments Receiving External Partner Support
	Generate global guidance/standards	China, Philippines
	Provide expert opinion upon request	Chile, Brazil
	Generate global/regional estimates	
	Provide focused TA for evidence generation	Ethiopia, Colombia, Vietnam
	Provide funding for monitoring system	India
	Facilitate stakeholder engagement	Vietnam, Ghana
	Support design of communication strategy	Phillippines
	Fund HBP through sector wide approach	Rwanda, Kenya, Uganda (?)
	Provide recommendations on design decisions	Ghana, Rwanda, Kenya, Indonesia
	Provide funding for specific goods/services	Ghana, Rwanda
	Play an integral role in design	Ethiopia, Honduras

Source: Authors

Looking ahead, what can donors do to support governments seeking to design evidence-based HBP policies?

- Support LMIC governments to strengthen priority-setting institutions for HBPs by investing in:
 - Systematic reviews and health systems level analysis, in addition to “single studies, articles and reports” like research into disease/health area specific areas [30] to directly support cross-intervention comparisons within the health sector.
 - Global and regional estimates of needed evidence (e.g. of CE analysis and unit cost data) as well as other types of guidance documents such as WHO’s Package for Essential NCDs Disease Interventions for Primary Health Care in Low-Resource Settings” that can be used by LMIC with country adaptations
- Build capacity of governments to translate research into relevant material to support prioritization. Just delivering the report is not enough, either because the report is not read or because its relevance is not understood during the cycle of policy action.
- Support local priority setting as part of HBP design and update; try to minimize the impact of external partner priorities on local governments.

5. CONCLUSION

Explicit priority setting is a way to take deliberate actions that align the distribution of resources to health system objectives. Many governments are purposefully turning to HBPs specifically because of their potential for making progress towards UHC. However, not all HBPs are alike. The authors of this report argue that HBPs based on evidence have a higher likelihood of increasing equity, access to services, and financial protection over the long-term. Additionally, unless measures are taken to be transparent about processes for designing and updating the HBP, it may not actually be explicit or reap the benefits of making resource allocation decisions explicitly. This review of country experiences highlights a number of emerging lessons that are relevant for all countries regardless of available resources or the maturity of the HBP.

More research can be done to better understand how donors can play a supportive role to LMICs at all stages of HBP development to make stronger, evidence-based HBPs. Additional in-depth country-specific case studies that document the process of HBP design and update—highlighting the role of evidence and the types of institutional arrangements and processes that can best facilitate use of evidence in an HBP—would also support LMICs currently working on HBP policy.

ANNEX A: METHODS

- A. Data Collection: This research relied on reviews of literature as well as key informant interviews.
- Published and grey literature were identified through keyword searches by country name plus “universal health coverage,” “health benefit package,” “health benefit plan,” “explicit priority setting,” and country specific public sector health insurance and national health financing mechanisms (e.g. PhilHealth in the Philippines, the National Health Insurance Scheme in Ghana, etc.).
 - Reports and websites from the Joint Learning Network for Universal Health Coverage (JLN), World Health Organization, Pan American Health Organization, World Bank, African Development Bank, Asian Development Bank, and Inter-American Development Bank were also mined for relevant information.
 - Interviews were conducted with members of the JLN in fall 2014. Key informants include current and former representatives of the governments of Ghana, India, Malaysia, Mexico, and the Philippines as well as health system stakeholders in Ethiopia, Vietnam, and South Korea.
- B. Sample Selection: Using three initial screening criteria (population size; political stability; stage of UHC design), 99 of 214 countries were excluded due to population size under 4 million or high political instability. Next, a quick search of known resources (e.g. the World Bank’s UNICO reports, the World Health Organization’s UHC Partnership, and the Inter-American Development Bank’s publication on Health Benefit Plans in Latin America) and key websites (e.g. World Bank, WHO, and JLN) was performed to identify countries for which there is publicly available relevant content, narrowing the sample to 46 countries. Further review of several primary sources (UNICO, WHO) allowed prioritization of 25 countries spanning a diverse range of incomes and geographic locations. The final sample comprises six countries in USAID’s Ending Preventable Child and Maternal Deaths program (EPCMD) as well as nine member countries of the JLN. Where relevant, the paper also draws upon other comparative country examples.

Table 4. Sample countries by region and economic classification¹⁴

World Bank Economic Classification	East Asia & Pacific	Europe/USA & Central Asia	Latin America & Caribbean	South Asia	Middle East & North Africa	Sub-Saharan Africa
High-income	South Korea (NHI)	Germany (Statutory Health Insurance), USA (State-level Medicaid)	Chile (AUGE), Uruguay (PIAS)			
Upper-middle income	China (Public insurance schemes, with a focus on the Common Disease Outpatient HBP in Zhuhai municipality) Thailand (UCS)		Argentina (Plan Nacer), Brazil (PCS), Colombia (COS) ~, Mexico (Seguro Popular - CAUSES) ~, Peru (PEAS)		Turkey (Yesil Kart)	South Africa (NHI)
Low-middle income	Indonesia (Jamkesmas) *~ Philippines (PhilHealth) ~ Vietnam (SHI) ~	Kyrgyz Republic (State guaranteed HBP)	Honduras (PBS)	India (RSBY) *~		Ghana (NHIS) *~
Low-income						Ethiopia (CBHI) *~ Kenya (NHIF) *~ Rwanda (CBHI) * Uganda * (UNMHCP)

*EPCMD Countries ~JLN Countries

¹⁴ The research team also looked at several other governments' experiences, including those of Costa Rica, Georgia, Malaysia, Namibia, and the United Kingdom. However, this final list reflects only those governments with a) explicit priority-setting policy instruments for UHC, and b) experience documented or available to the research team.

ANNEX B: ROLE OF DONORS IN SAMPLE COUNTRIES

A. Light Support

- **Global guidance on process for HBP and more generally explicit priority setting:** Examples include the heavily cited Giedion et al. 2014, and Glassman and Chalkidou 2012 [3, 26], among others. Also included are frameworks and methods for prioritization [36].
- **Global level data:** Growing availability of this type of global guidance and material (e.g. DCP2 and WHO-CHOICE). Global level data is considered by some as good way for low-income countries to apply, and reap benefits of, an evidence-based approach to HBP design and updating. The more that governments can adapt global and/or regional health-sector CEA estimates to the local context, the better the HBP will reflect local realities. If governments do not leverage this resource, they may face the challenge of having a lot of disease specific studies that do not cover the full spectrum of possible interventions—both existing and new. However, others in the global health community question the applicability of these global/regional estimates.
- **Expert opinion upon request:** While not ultimately utilized, Colombia attempted to use explicit cost-effectiveness criteria with the support of an internationally recognized “dream team” of experts [29]. Chile requested approval from various international experts/organizations of the development of the HBP (academics from London School of Economics, Norman Daniels—an expert on public health ethics at Harvard) and presented the HBP design at various international forums (e.g. an activity organized by the Rockefeller Foundation in Bellagio) [33]. International academic institutions have assessed *Seguro Popular* in Mexico [20].
- **Facilitating knowledge/experience sharing:** As previously discussed, there is a need for more exchange of experiences on the process of designing HBPs as well as use of evidence. International literature on the topic is scarce, particularly at a global or regional level. “This accumulated knowledge is not easily accessible to policymakers and others interested in the subject, as it is dispersed among government agencies, specialized professionals, research institutes, and consulting firms.” [26].
 - To facilitate this knowledge transfer, initiatives such as the JLN—a global community of practitioners and policymakers who share knowledge and co-develop new tools, guides, and resources that address the practical challenges of health systems reform [40]—serve as valuable resources.
 - Regional knowledge sharing spaces also exist. For example, the IDB implemented a regional knowledge transfer project on HBPs including “methodologies for priority setting, costing, budgetary impact assessment and monitoring, as well as lessons on the processes and institutions necessary for the plans to be technically and politically viable” [26].
 - Knowledge sharing is not limited to LMIC countries. Relevant lessons can be learned from higher-income countries as well—e.g. independent institutions such as the National Institute for Health and Care Excellence (NICE) in the UK and the German Institute for Quality and Efficiency (IQWiG).

B. Medium Support

- Focused technical assistance for evidence generation:

- A common failing is that donors help with design but not with application or sustainability [3].
 - In Honduras, donors prepared analyses and recommendations but did not necessarily provide sufficient support to the government to interpret and translate that evidence into actionable steps[26].
 - “Donors tend to promote interventions with strong evidence bases, but they do so in ways that may neglect local context, needs and capabilities” [38].
 - Donors could help with analytical support and collection of local epidemiology and cost data to support an informed decision [26].
 - New efforts working to address sustainability challenges and building institutional capacity:
 - Some technical assistance providers are investing more in capacity building for stronger local priority setting [11]. The need for this type of investment has been highlighted in the literature as a key role that donors should play [1, 41].
 - On a country level: In Vietnam, emphasis on good evidence and stakeholder engagement [11].
 - On a technical level: The Supporting Independent Immunization and Vaccine Advisory Committees Initiative (SIVAC) builds the capacity of National Immunization Technical Advisory Groups (NITAGs) and in some cases provides support to carry out cost-effectiveness studies of new vaccines/new vaccine technology [3].
 - **Facilitating stakeholder engagement:**
 - In some contexts, the external nature of evidence generation can promote legitimacy because it is more objective than if generated from local institutions. Vietnam, which has the capacity to generate its own evidence, has still asked for donors to act as a third/neutral party to provide capacity building in reviewing evidence or supporting policymakers through the HBP design process.
 - **Providing funding for monitoring systems:** Countries can also attract donor support for monitoring systems by showing a commitment to collecting and evaluating quality data. *Plan Nacer* (Argentina) received international recognition for the methodological rigor applied to an impact assessment and attracted additional sources of funding, including the Spanish Impact Evaluation Fund (SIEF) and the Norwegian fund known as the Health Results-Based Financing Fund (HRBF) [28].
 - **Providing budgetary support through a sector-wide approach:** This type of pooled financing can support local ownership and strengthen capacity for indigenous priority setting [1]. Problems with transparency and accountability can emerge and in some cases have prevented this approach from spreading.
- C. Strong Support
- **Provide recommendations on design decisions:** Peru’s Ministry of Health (MINSA) requested technical assistance from the Promoting Alliances and Strategies (PRAES) project of the U.S. Agency for International Development (USAID) in preparation for the first version of its HBP. In readjusting the HBP in 2011, MINSA requested PRAES’ help to verify the consistency between insured conditions and their benefits. During the review, some aspects of the HBP were improved, and

MINSA staff were responsible for making calculations and conducting a review of the evidence to build capacity and transfer responsibility from international experts to MINSA staff [24].

- **Providing funding for goods/services:**

- Donors may provide vertical funding for priority goods/services as part of health systems strengthening support.
 - Family planning in Ghana is currently funded by USAID, thus family planning is not included in the HBP (versus being excluded as part of a prioritization process).
 - In the absence of public financing for a service or technology, priority setting—when implemented under an explicit and institutional framework—can help countries assess recommendations and suggest technologies for fair and ethical consideration and inclusion in donor budgets [3].

- **Play an integral role in design:**

- The design of an HBP in Honduras was not necessarily part of national policy—the HBP was developed on the recommendation of international cooperation projects designed to address access to health services for vulnerable populations [32].
- A common failing in situations where donors provide a “heavy” footprint—often due to significant financial support—is that such HBPs are donor driven. The Government of Uganda relies heavily on external assistance for financial support, thus priority setting can be significantly influenced by stakeholders contributing to the health budget. In Uganda, there has been criticism that the HBP does not fully consider the Ugandan context [42].

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