IMPROVING DECISION-MAKING THROUGH BETTER TOOLS

March 6-10, 2017

This report covers the Health Benefits Package Workshop, the first launch of the Guide to Health Economic Analysis and Research (GEAR) online resource, and the iDSI March 2017 Board Meeting.

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Disclaimer Page

This report is written as documentation for the Health Intervention and Technology Assessment Program (HITAP) and HITAP International Unit's (HIU) activities. The information may not be fully representative of all the discussions during the meetings. HITAP and HIU's activities are funded by the grant to the International Decision Support Initiative under the Bill and Melinda Gates Foundation (BMGF), the Rockefeller Foundation (RF), and the Department for International Development (DfID, UK). HITAP operations is supported by the grant through the Thailand Research Fund (TRF).

The findings, results, and conclusions do not necessarily reflect the views of the funding agencies.

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List of Acronyms

BP	Benefits Package
BIA	Budget impact analysis
BPJS	Badan Penyelenggara Jamina Sosial (Agency for the Organization of Social Insurance)
CEA	Cost-effectiveness Analysis
CNHDRC	China National Health Development Research Center
COI	Conflict of Interest
DALY	Disability-adjusted life years
D.C.	District of Columbia (Washington D.C.)
DEG	Delivery Executive Group
EML	Essential Medicines List
DRG	Diagnosis Related Group
EHP	Essential Health Package
GEAR	Guide to Health Economics Analysis and Research Online Resource
GF	Global Fund
GHD	Global Health and Development Team
HBP	Health Benefits Package
HePTA/HTA	Health Technology Assessment Program in the Mahidol University
HITAP	Health Intervention and Technology Assessment Program, Thailand
HIC	High-income countries
HTA	Health Technology Assessment
IC	Imperial College
ICER	Incremental Cost-Effectiveness Ratio
ISPOR	International Society For Pharmacoeconomics and Outcomes Research
IDRC Canada	International Development Research Centre
iDSI	International Decision Support Initiative
JKN	Jaminan Kesehatan Nasional, universal healthcare program
LIC	Low-income countries
MoU	Memorandum of Understanding
M&E	Monitoring and Evaluation
NHA	National Health Accounts
PRICELESS	Priority Cost Effective Lessons for Systems Strengthening South Africa
PPJK	Centre for Health Financing, Indonesia
QALY	Quality Adjusted Life Years
QoL	Quality of Life
SOP	Standard Operating Procedures
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

With governments around the world committing to Universal Health Coverage, it is increasingly important to ensure that they have the right tools to the address the challenges they will face. Evidence-informed decision making to ensure efficient allocation of resources in the system is vital. The International Decision Support Initiative (iDSI), in pursuing its goal to assist policymakers in using evidence for healthcare, supported the development of two knowledge products. The book "What's in, What's out: Designing Benefits for Universal Health Coverage" and the Guide to health Economic Analysis and Research (GEAR) Online Resource were launched in South Africa from March 6-8, 2017.

The health benefits package is the set of services that are made available for the public. This means they are decided on implicitly or explicitly to account for constrained resources. No country can offer access to all available treatments; therefore, serious discussion needs to take place to allocate the funds available in an efficient manner. "What's in, What's Out" aims to assist policymakers in creating an explicit health benefits package. A two-and-a-half-day workshop was conducted from March 6 – 8, 2017. On March 9, 2017, a meeting with high level stakeholders from South Africa (and larger sub-Saharan Africa) was held to discuss their health benefits packages and what next steps they will take to formalize or improve them. The editors of the "What's in, What's out" book, Dr. Amanda Glassman, Dr. Usula Gideon, and Prof. Peter C. Smith, coordinated the discussions over the three days.

In keeping with this goal, the HITAP team also launched the GEAR – a global platform designed to assist researchers in low- and middle-income countries (LMICs) conduct policy relevant and high-quality health economics research. According to HITAP's study in 2015, researchers in LMICs face different methodological challenges in conducting economics research for healthcare. The GEAR provides immediate solutions to these challenges through visual mapping of solutions, providing guidelines, and connecting researchers with experts who can respond to their queries.

Finally, the International Decision Support Initiative (iDSI) continues to provide assistance for evidence-informed priority-setting globally. The members met on March 10, 2017, for the board meeting to discuss the achievements and plans for the coming year, the managerial aspects such as finances and deliverables, communications, global partnerships, and other issues.

Objectives:

1. To launch the GEAR to a global audience.
2. To support the launching of the "What's in, What's Out" health benefits package guide.
3. To facilitate the next steps for the iDSI alongside its partners.

Introduction

HITAP's work notably expanded to the international level in 2013 when HITAP International Unit (HIU) was established under HITAP with the main objective to provide support in building HTA capacity in low- and middle-income countries (LMICs). In collaboration with international partners such as NICE International (now the Global Health and Development team in Imperial College), UK, HITAP provides technical support and shares the Thai and other international experiences in generating and using HTA evidence to inform policy decision-making to individuals from various developing countries such as Indonesia, Vietnam, Bhutan, etc. The support is provided in different forms, namely through study visits, technical workshops, trainings, internship and fellowship programs which may be on a one-off basis or part of a long-term collaboration, as in the case of Vietnam and Indonesia. In addition, knowledge transfer and exchange and experience sharing is also done through activities under HTAsiaLink, which is a network of HTA agencies in the Asia-Pacific region of which HITAP is a founding member. The network, established in 2010, is a means of building capacity of research staff from member organizations to strengthen HTA competency in the region.

Though its researchers have visited the country for conferences, workshops, and meetings, HITAP does not have a specific project in South Africa, or sub-Saharan Africa for that matter. However, through the International Decision Support Initiative, HITAP will be supporting the development of a South African HTA hub in PRICELESS, which has designs to aid the rest of the continent in the future. The hub in South Africa will be modelled after the HTAsiaLink and HITAP will assist PRICELESS on its development. Toward this end, in November 2016, HITAP attended a South-South Collaboration workshop organized by Imperial College and PRICELESS in Johannesburg, South Africa. HITAP has also provided introductory HTA workshops in Ghana, Tanzania, and other countries with iDSI and other partners in previous years as a preliminary move towards this goal.

HITAP is also building the Guide to Economic Analysis and Research (GEAR) online web resource which aims to provide immediate solutions to researchers in low- and middle-income countries for their methodological challenges in economic evaluation. This resource will be connected to the PRICELESS work and network and will be launched during the Health Benefits Package (HBP) workshop (6-9 March 2017) prior to the iDSI Board Meeting (10 March 2017). This launch aims to introduce the GEAR resource as well as gather feedback on its usability, content, features, and future development. Note: the board meeting minutes are not included in this version.

This HBP workshop was expected to gather participants from various countries and not just Africa. They will share perspectives/experiences in developing next steps and recommendations for their own health system building, what needs further development, and what other materials and input will be needed to enhance results in terms of HBP policies. HITAP's participation in the workshop as well as the board meeting is part of its goal in addressing global and country needs for HTA development, facilitating networks and productive relationships, and planning for future work.

Health Benefits Package Workshop

Introduction

Mrs. Amanda Glassman, the editor of the "What's in, What's out" book introduced the workshop and the book. Called the HBP Guide book, it puts together practical advice and information about how to decide what interventions medicines, and technologies should be subsidized by public monies and how different countries went ahead doing that in their local contexts. For more details on the workshop introduction, refer to the agenda in Workshop on Designing and Adjusting Health Benefits Plans for Universal Health Coverage under Appendix 2: Miscellaneous Notes.

UHC would mean to improve coverage, financial protection, essential services, better equity which was discussed throughout the workshop. Implicit rationing means that who gets what are decided in an ad hoc way without letting the relevant stakeholders in on the reasoning. The first session explained why explicit benefits for UHC should be set and why it will be difficult. A key lesson learned while writing the HBP book is that this is a very technical topic, but also very political, institutional, procedural and must inform all the relevant groups of people involved. HBP is a relevant tool because any system that takes provision and purchasing and separates them must have an agreement in place between the provider and purchasers for services to help achieve UHC outcomes. Some examples of using HBPs are:

- Examples from Thailand where ICERS have been used for inclusion or exclusion of interventions from their package. In Thailand, the costs for conducting economic evaluation studies have been easily covered from the savings gained through this process.
- Another way of which health benefit plans can be used is to reform provider commissioning payment. An example is of China when they found there is over prescription of antibiotics and vitamins, they added partial copayments.
- Another way is to maximize benefits from given budget constraints.
- Finally, HBP can be used to reduce waste or outweigh harm through quick assessment to revise existing list of interventions and indications.

While writing the book, they found that efficacy data tends to be similar in many settings whereas cost-effectiveness, affordability, and clinical data are local. Good practices include publishing the results of costing study updates, as in Chile. One issue in high-income (HIC) and middle-income (MIC) countries is the creation of separate packages for high cost drugs and separate sources of funding. As a result, interventions are selected based only on prices, with the HBP filled with expensive interventions and not necessarily with those that are most effective and safe. Another common pitfall of HBP are the inclusion of plastic surgeries. Platforms from which conclusions are drawn (for example, national vs. state level decisions) should be similar in-country,

Policymaker Perspectives

Policymaker perspectives from three countries were shared. Thailand's Mrs Netnapis Suchonwanich showed that, in the HBP process, there can be much political pressure and governance problems, there is often a large bulk of data

that may or may not be relevant to the work, and costing is very difficult. Mr Mpuma Kamanga also shared that, in the Zambian context as in similar settings with donor involvement, a challenge has been in their involvement in the decision making and the lack of capacity (which defaults in using international consultants). Another challenge is the management of different interest groups to push the agenda for certain diseases and interventions. Mr Gerald Manthalu shared that, in Malawi, they have challenges in both the supply and demand side delivery, financial and health system constraints, not the best interventions, and ethical considerations.

Dr. Ursula Giedion then introduced the main concepts for a well-functioning HBP system in terms of governance – which could also be the main issues in its implementation. These include: transparency, HTA system and processes involvement in the BP development, participation of stakeholders, management of key stakeholders and conflict of interest (COI), consistency and coherency in the governance system, non-fragmentation of the BP system (which can lead to undesirable results), and the risks and costs of good governance. Discussion points during the session include: lack of proper design of stakeholder participation; real implications and fatigue of stakeholders with the introduction (and/or failure) of new systems; institutional uncertainties, prioritization of programs (budget holders and buyers), role of engaging the press and media in sharing the information and accessing resources, funding mechanisms, and the discrepancy between national programs and state-level implementation in some countries.

Governance of the HBP

Five key ingredients for a sustainable HBP include the following. Firstly, the process of setting up and adjusting HBP should be practical and feasible. Secondly, support from key stakeholders should be secure – they want to have a voice, know what, why, how to do things, trust in what the government is doing, and, with trust building up over time when the processes are applied consistently over time. Thirdly, HBP should be affordable and implementable: be coherent with resources and other public policies. Fourthly, the HBP gets adjusted over time: evolving policy instrument that should adapt the new needs, with monitoring and evaluation. Fifthly, the HBP must be in line with goals and serves its purpose of setting limits: make sure goals are a key element when deciding what will be included in the future.

Transparency was also discussed as part of the processes and policy cycle for the content of the HBP. It refers to availability, standardization, and timely and up-to-date information, useful in conjunction with other policy tools. Some examples of stakeholder participation include Chile having surveys and focus groups to include specific groups' concerns in the HBP (e.g. dentures for older women). Key issues include management of COI through clear processes and systems, strategic use of resources for transparency, using non-pro-forma validation, institutionalizing processes, and consistency and coherence of HBP with other issues in the design. Ensuring that the participation process is well-designed and accepted by all stakeholders is important.

Understandably, HBP planning and implementation can be difficult for politicians because it is not rewarding to the political business to pursue HBP and makes the sustainability of the HBP policy a difficult goal in a difficult context. One example of bad governance was when HBP was removed from Colombia due to lack of coherence: president announces that there is UHC so the allocations are controlled, but that doctors can have autonomy and prescribe as they see fit, and courts saying

patients are the priority. Good governance can also be a risk because it is resource (time, money, and personnel) intensive, can be too formal, and can backfire (e.g. participation becomes counterproductive or too much transparency leading to a culture of blame).

Some points raised during the discussion session covered the question on changes in leadership and champions for the HBP, if in case they are not renewed for a new term in government. Example approaches include tying it to the finances or having more concrete processes. Another point raised was on the involvement or influence of Gavi, Global Fund, and other international donors in government planning. Responses include having a credible process to manage it and ensuring that the press and media covers these stories. While countries should dictate the policy, donors may still be accountable to their domestic requirements in terms of responding to the needs of other countries.

Group Work on Governance

A group work on assessing the choices around governance and process underpinning the HBP policy was conducted. The group work discussions yielded the following main points. While there may be rules or policies, it is unclear who would implement them. There are also no clear mechanisms to inform citizens. There is also political over-commitment. In some cases, within institutional framework, there were bodies required to do this but it is not necessarily happening in practice; there was a complaint mechanism addressing individual issues but not necessarily feeding them back to the process. One recommendation is to monitor payment systems and mechanisms because HBP can sometimes have unclear link to the financial aspects, etc. Another is to create agreement across political parties (e.g. in the US, the smart way to preserve Obamacare would be to get bi-partisan support and prevent its removal with a change in government).

HBP Fiscal Budget and Plans

Important parts of HBP are the fiscal budget and plans. Budgets can have mismatches and conventions that may prevent efficiency in the system; earmarked donor funds can also be another area of consideration. Planning also needs to account for any changes in the future in terms of inflation, new inclusions, and the economic cycle. While grandfathering may be easy at first, it is problematic over time. Often, there is no budget impact analysis conducted in countries as well. To address these issues, recommendations include: having macro policies that can fit budget to time; making sure that BIA is part of any analysis that comes your way; learning along the way through monitoring and evaluation; limiting multiple budgetary conventions which can dilute the power of priorities (e.g. different incentive environments can be difficult for providers' management); ensuring that there is clear accountability for service provision (e.g. grafting a package onto an input-based budget on the provider or even state level can be counter-productive); managing the budget risk holder (how big as a budget holder, how good the costing, and how big the changes in inflation, and the budget risk formula); linking medicines on essential medicines lists or EMLs should be linked to indications, clinical guidelines or Diagnosis Related Group (DRGs are not just for payment and quality measurement, but a structure for coding and billing in hospitals); and, minimizing budgetary risk, preventing risk selection, maximizing equity: don't want to enable non-legitimate budget runs (n.b. DRG cannot cover all costs).

One issue is donor support, especially for LICs. They cover many cost-effective interventions. However, this creates an ethical imperative to maintain that intervention over time, giving rise to

entitlements where reallocation in resource-limited settings is difficult. Often, they also require co-financing, can be unpredictable from year to year, and may also downgrade their support. Therefore, they are usually left out of the planning for domestic HBP, e.g. the case of Vietnam and Ghana that are about to graduate from GF and now are unable to include the GF interventions in the HBP. Some models include donors in the process, though this can be unwieldy as donors may operate on different requirements and specifications.

During the discussion session, the following salient points were mentioned. While there may be data collected from national health accounts (NHA), it may be too specific for NHA and unusable for HBP purposes. Efficiency gains and reducing waste in the system can provide leverage; but if fraud is controlled and inefficiencies managed, this will be difficult. For analyses conducted for the HBP, thresholds can act as a stop-gap measure and be used as part of the budget or willingness-to-pay for others. Increasing value-for-money should be considered, e.g. through price controls or guidelines. Having a decision tree for countries with or without NHA could be useful. Normative vs policy system is the balance between policy and budget constraint and technical guidelines.

Country Experiences

Country experiences of HBP development were shared. Mr McGuire discussed the situation in Malawi, where they used CEA in their implementation of the Essential Health Package (EHP). They had a long list of 250 plus interventions ranked according to net DALY averted. They included all interventions until the net DALY averted was 0; that formed the package on purely cost-effectiveness burden. Despite this, implementation is minimal since there were two HBPs: the actual purchasing and provision of interventions vs. the aspirational one. In addition, there already exists a minimum package that costs more than the resources available. Dr Yot Teerawattananon shared about the Vietnam case that is supported by iDSI. They selected priority issues and revised the HBP to remove the interventions that are high cost but without any clear evidence on their safety and efficacy. Mr Thomas Wilkinson shared about the process in South Africa particularly the unique situation of Pharmac (wherein the budget is set by the minister). They've been trying to link implementation strategies. During the discussion, the participants mentioned that stakeholder consultation needs to be more formal and stakeholders should be careful what they say. Establishing a process and being more realistic would be helpful in the future.

Ethical Considerations

Dr. Carleigh Krubiner discussed the importance of focusing not only on what goes into the HBP but also on why they did or are. A pitfall of designing and developing the health benefits package is facing unintentional and avoidable harm. This can lead to potentially reinforcing or worsening systematic and ineffective allocation that could have been used for important health gains and well-being of the population. This results in loss of public trust. There are various frameworks of ethical analysis, but most of them share similar fundamental concept such as health maximization, giving priority to the worst off, and avoiding harm. In any context, there may be unacceptable tradeoffs for the different stakeholders; there may be shortcomings from different stakeholders in recognizing what is feasible. For example, there is a wider ethics issue on allocating health resource for all the population rather than the ethics for the doctor at clinical level. Despite this, it is important to include all in the considerations, including the respect for the dignity of patients, the respect for clinician judgment, and others. She discussed what equity means (doing what is just and fair, often about how to fairly

distribute goods, resources, opportunities, costs, and burdens across a population. In addition, equity can be beyond income) and having a holistic view to outline the set of considerations in HBP. While efficiency (assessing the value-for-money of various services in the plan, prioritizing low-cost and high-value services, with limited to no investment in high-cost, low-value services) is important and CEA can provide much, it's not the whole picture and can't wholly be relied on. The solidarity or harmonization of HPB should be considered. Although ethics share similar principles, it is context specific and can be applied differently. Committing to fair processes, as expressed through the inclusion of relevant stakeholders in participatory processes or public engagement means that as more people engage, the more cooperative people are.

Group work activities on the last day are outlined in the notes section in Health Benefits Design Group Work.

Closing Remarks

During the closing section, the three editors, Prof Peter C. Smith, Dr Ursula Giedion, and Amanda Glassman gave their closing remarks. Prof Smith mentioned that it is important to articulate the care that is needed and the conditions. It's also important to look at the perspective adopted and the cost structures, as well as the involvement of donors. The HBP does not start from zero-base, so it is necessary to begin from what is available. Political commitment is fundamental. There is tension between keeping the principles of analysts and policy advisers as well as keeping the funding going. UHC should be seen as a way to provide major health benefits to the population and across the health system. Dr Giedion discussed the need to explore not just HTA but also health policy and planning research and methods. In practice, it may be difficult to align the HBP to the health structure so there is a tremendous task of harmonizing that triage. Information systems are also important to include in the development of HBP. The course explored static versions of HBP; but over time, it will evolve so the process, the accountable parties, and what their collaboration would look like and how to manage the different interests. Coherence with benefits package and allocation for benefits package as well as with our policies, pricing, provider payments is important. Mrs Glassman mentioned that international organizations that support vertical programs or single-disease projects should look at ensuring a more comprehensive approach. She said this workshop is the birth of the HBP guidebook and tool and they look to revising it and expanding to online courses and other distribution platforms in the future.

GEAR Launch

A workshop to launch the Guide to health Economic Analysis and Research (GEAR) was held on the last day of the workshop. The workshop introduced the GEAR and its background. The database is designed as a global public good dedicated towards helping low- and middle- income countries (LMICs) academics, researchers and economic evaluation practitioners worldwide conduct high quality, policy relevant healthcare research. The database not only explores the issues in the conduct and the use of these evidences, potential solutions to the issues and future research questions to address these issues but also will it provide various alternatives to solve specific methodological difficulties researchers may encounter in the conduct of their studies.

HITAP provided a practical demonstration of the website and its uses, as well as gathered feedback on the GEAR's functions. They showed the main features of the GEAR, which are: visualizing the methodological difficulties through a mind map; exploring guidelines; and, asking experts for possible solutions, in case they are not already in the website. Then the participants had the chance to use the website and work through an exercise. They provided written feedback to feed into the next phase developments of the GEAR. Finally, they reviewed the event's effectiveness and whether they would use the GEAR for their activities.

Figure 1:

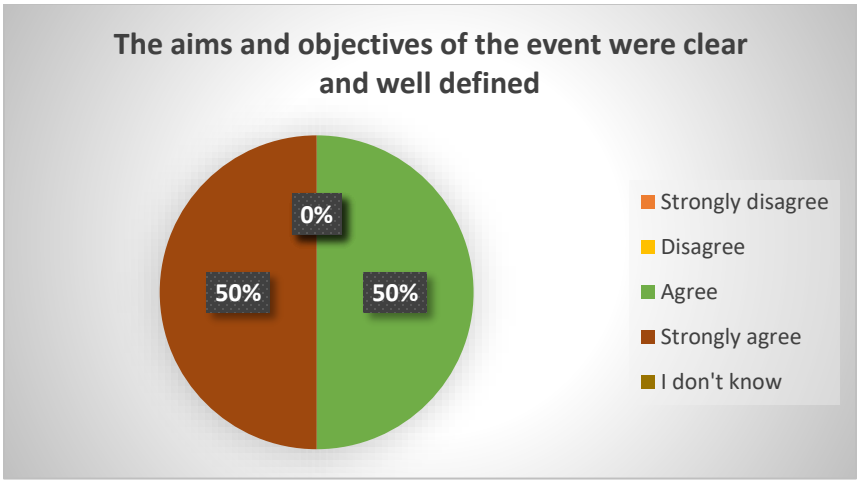


Figure 2:

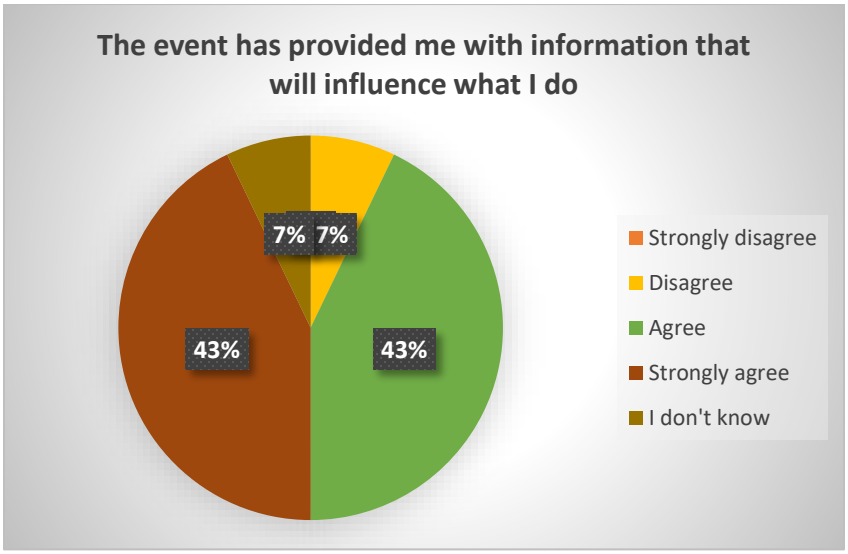


Figure 3:

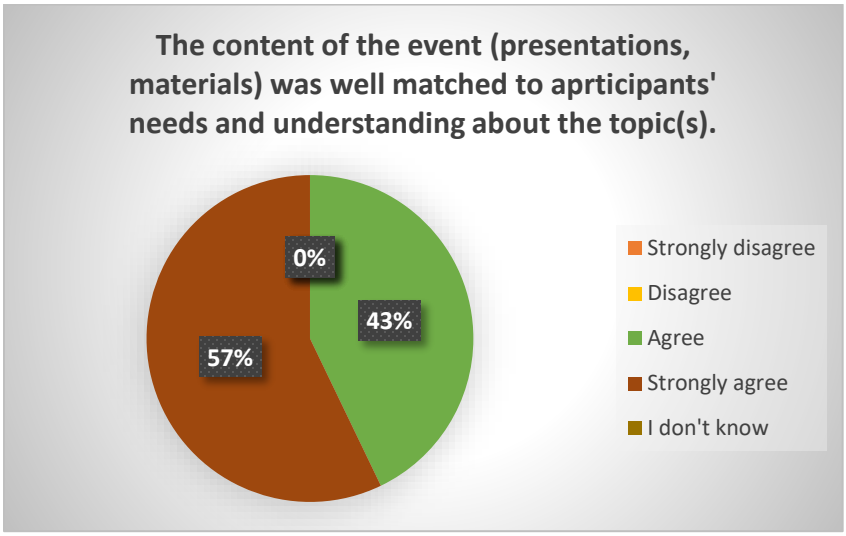
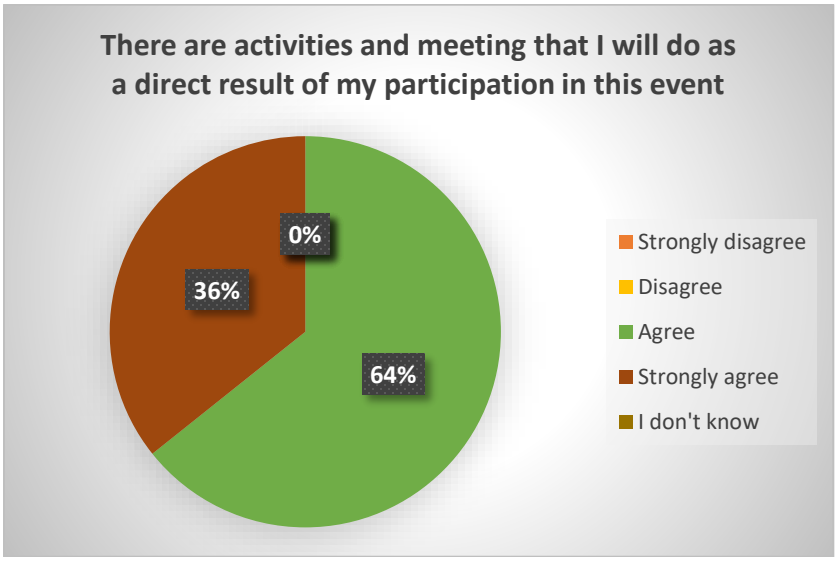


Figure 4:



Fourteen respondents had favorable impressions of the event. Most felt that the objectives were clear and the content was presented well. They also mentioned that they will be using the GEAR in their future activities. In the qualitative section, the respondents cited the following: using the GEAR for pedagogical purposes (teaching economic evaluation); networking and exchanging information with other economic evaluation researchers; using the GEAR for conducting HTA; and, using the GEAR to

for the guidelines comparison tool. For improvements on the activity, the participants suggested more country cases to be included.

Miscellaneous Meetings

Meeting with BPJS Indonesia	HITAP discussed the possibility of providing the higher education training for Indonesian partners through the BPJS. The program under Mahidol U. will start in July. The participants can be Master's or PhD. HITAP will also work through PPJK.

Dr. Yot discussed the possibility of having separate support for BPJS and so he requested that the outline of the details be discussed during HITAP's visit to Indonesia in March 2017. He also suggested that a timeline for the scholarship be prepared. Finally, he mentioned that there is an initiative for a payers' agency workshop for iDSI countries of work to be done in 2017 and invited BPJS to attend.

Appendices

Appendix 1: Agendas

DRAFT AGENDA

International Seminar on

Using Evidence for Decision-Making and Health Benefits Package Design

WORKSHOP:

What's In, What's Out?
Designing and Adjusting Health Benefits Plans for Universal Health Coverage

Monday, March 6th, 2017–Wednesday, March 8th, 2017
Sheraton Pretoria, South Africa

This workshop aims to:

(i) Describe the role of health benefits plans in modern health systems, drawing practical policy and implementation lessons
(ii) Present and discuss a range of concrete examples from low- and middle-income countries
(iii) Discuss how health benefits plan-based policies can be operationalized considering resource and information constraints as well as context
(iv) Pilot the workshop material and provide feedback into the final version of a book based on the material

Here's how it will work:

The experiences of workshop participants will be central, with participants sharing their perspectives and developing next steps and recommendations for their own health system building on the themes of the course. They will also be able to engage in dialogue with senior policymakers and scholars engaged in the issues, with the goal of two-way learning.

This will be the first version of the workshop, and is aimed at learning what will and won't work, what needs further development, and what other materials and input will be needed to enhance results, building from the idea of two-way learning.

Materials:

One week prior to the workshop, participants will receive the draft manuscript of the HBP book, along with the short case study that will be discussed at the end of day 1 as part of the governance group work. Presentations, videos and related materials will be made available on the IDSI website shortly after the conclusion of the workshop.

DRAFT AGENDA

MONDAY MARCH 6, 2017

9:00 am – 9:15 am
Welcome and introductions
Kalipso Chalkidou, Imperial College London – IDSI
Amanda Glassman, CGD - IDSI
- Structure of workshop: introduction, governance, methods, rights and ethics – introduction followed by 3 modules – governance; methods; rights and ethics
- Distribute today's session-by-session evaluation form

9:15 am – 10:30 am
Why set explicit benefits for UHC? Why will it be hard?
Presentation and group discussion led by *Amanda Glassman*
- Rationale for explicit benefits in the context of UHC
- Political economy challenges to establishing explicit benefits
- Overview of the policy cycle associated with HBP policy

10:30 am – 11:00 am
Coffee break

11:00 am - 12:30 pm
What is your HBP policy baseline? Where did you start?
Policymaker viewpoints (10 min each)
Netnapis Suchonwanich, Thailand
Yogan Pillay, South Africa
Mpuma Kamanga, Zambia
Gerald Manthalu, Malawi
Small group work and report back led by *Rachel Silverman* and *Amanda Glassman*
- Goal is to understand the issues and challenges in your particular context
- Choosing a specific decision about a medicine or device, or choosing your current HBP policy as a whole, how does priority-setting or HBP decision-making operate currently in your country? Who or what organizations/offices are involved? How are decisions taken on different parts of the budget? How are resources allocated?

12:30 pm – 1:30 pm
Lunch

MODULE 1: GOVERNANCE OF THE HEALTH BENEFITS PLAN POLICY

1:30 pm – 2:00 pm
Determining the institutions and processes for designing and adjusting the HBP
Presentation and group discussion led by *Ursula Giedion*
- Principles of good governance for setting and adjusting HBP, country examples of good process
- Options for institutional arrangements to support the HBP policy

2:00 pm – 2:30 pm
Examining current governance and understanding options
Policymaker viewpoints (10 min each)

DRAFT AGENDA

Mark Blecher, South Africa
XX, Ethiopia
Yot Teerawattananon, Thailand

2:30 pm – 2:45 pm
Coffee break

2:45 pm – 3:45 pm
Group work on governance
Small group work followed by reports back led by *Ursula Giedion* with support from *Rachel Silverman*

- Case study to assess a fictional country's choices around governance and process underpinning the HBP policy

3:45 pm – 4:30 pm
Fiscal and budgetary issues in HBP policy
Presentation and group discussion by *Amanda Glassman*

- Understanding common challenges
- Fitting HBP benefits to available resources over time
- Making budget coding and allocation conventions consistent with HBP goals
- Managing earmarked donor funds in the context of HBP policy

4:30 pm
Wrap Up

- Take-home messages
- Return today's evaluation form

DRAFT AGENDA

TUESDAY MARCH 7, 2017

9:00 am – 9:15 am
Check-in
- How are we doing?
- Distribute today's session-by-session evaluation form

MODULE 2: METHODS FOR THE DEVELOPMENT AND ADJUSTMENT OF HBP

9:15 am – 10:30 am
Methods options for HBP
Presentation and group discussion led by *Peter Smith*
- Understanding the role of different methods in defining and adjusting the HBP, what choices need to be made
- Principles and options underlying currently available methods (PBMA, CEA, HTA, ECEA, MCDA, etc.), contrasting actual practice and options, including transferability and use of external evidence, analyses and guidance

10:30 am – 11:00 am
Coffee break

11:00 am – 12:30 pm
Methods group work
Country experiences (10 min each)
Finn McGuire – Malawi and CEA
Waranya Rattanavipapong – Vietnam and evidence
Tommy Wilkinson – New Zealand and CEA/decision rules
Small group work followed by reports back led by *Peter Smith* and *Tommy Wilkinson*
- Case study to assess a fictional country's priorities for data and analysis when considering development of a HBP

12:30 pm – 1:30 pm
Lunch

MODULE 3: RIGHTS AND ETHICS IN HBP POLICY

1:30 pm – 2:30 pm
How to consider ethics and human rights in HBP decisions and decision-making
Ethics presentation and group discussion led by *Carleigh Krubiner* (45 min)
Country Viewpoint (15 min)
- Understanding a range of ethical considerations relevant to health priority-setting and HBP decision-making
- Articulating specific commitments and objectives for an HBP as they relate to ethical considerations
- Understanding how to use ethics language to justify HBP decisions
- Identifying how to tailor aspects of HBP implementation and monitoring and evaluation to fulfil and track progress on ethics objectives

DRAFT AGENDA

2:30 pm – 3:00 pm
Coffee break

3:00-4:15 pm
Small Group Discussions of Ethics Mini-Cases
Presentation of mini-cases by *Carleigh Krubiner* and *Aviva Tugendhaft* (5 min)
Breakout sessions to work through cases (45 min)
Reconvene to share experiences (15 min)

- Applying ethical considerations to specific cases of coverage decision that engage different kinds of ethical concerns and trade-offs

4:15 pm – 4:30 pm
Wrap-up

- Take-home messages
- Return today's evaluation form

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DRAFT AGENDA

WEDNESDAY MARCH 8, 2017

9:00 am – 9:15 am
Check-in, how are we doing?
- Distribute overall evaluation form

9:15 am – 10:30 am
Making it happen
Presentation and group discussion led by *Amanda Glassman*
Policymaker viewpoints by 3-4 South African provincial officials
- What's needed in terms of financial and human resources, time, legal action, etc., what are shortcuts and stop-gap measures, how to set priorities for priority-setting
- What are and how to overcome common obstacles (limited capacity, budget and political will) illustrated using country experiences

10:30 am – 11:00 am
Coffee break

11:00 am – 12:00 pm
Country teams action planning
Donors and helpers action planning

12:00 am – 12:30 pm
Wrap Up
- Take-home messages
- Feedback so far, return completed evaluation form

1:00 am – 2:00 pm
Lunch

(HITAP to hold GEAR launch in afternoon)

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Gearing up for Better Decisions:

Launching the *Guide to Economic Analysis and Research (GEAR)* Online Resource

Economic evaluations are increasingly becoming of interest to low- and middle-income (LMIC) governments, especially those keen to make efficient health care systems. However, economic evaluations can be useful for policy decisions only when they are conducted accurately and reported properly. Because economic evaluation is a relatively new discipline in LMICs compared to high-income countries (HICs), it's important to learn the methodological problems in conducting economic evaluations in LMICs and to address these issues accordingly.

In 2017, the International Decision Support Initiative (iDSI) through the support of the Bill and Melinda Gates Foundation (BMGF) and the Department for International Development (DFID), UK, and the Thailand Research Fund (TRF) will launch the Guide to Economic Analysis and Research (GEAR) Online Resource, which will compile and resolve gaps due to issues in the conduct and the use of economic evaluations. The database is designed as a global public good dedicated towards helping low- and middle- income countries (LMICs) academics, researchers and economic evaluation practitioners worldwide conduct high quality, policy relevant healthcare research. The database will not only explore the issues in the conduct and the use of these evidences, potential solutions to the issues and future research questions to address these issues but also will it provide various alternatives to solve specific methodological difficulties researchers may encounter in the conduct of their studies.

The database will be launched on March 8, 2016, in Johannesburg, South Africa, with this schedule:

Time	Activity	Presenter	Notes
14:00 – 14:15	Opening remarks	Prof. Anthony Culyer	
14:15 – 14:35	What is the GEAR online resource?	Dr. Yot Teerawattananon	Officially launch the GEAR online resource
14:35 – 14:55 14:55 – 15:30 15:30 – 15:40	GEAR website workshop • Introduction to features • Individual and/or Group Exercise • Feedback session	Ms. Alia Luz	 Online form
15:40 – 16:10	• Discussion on exercises and GEAR online resource	Dr. Yot Teerawattnanon to moderate	
16:10 – 16:20	Closing remarks	Dr. Suwit Wibulpolprasert	

This launch aims to introduce the GEAR resource as well as gather feedback on its usability, content, features, and future development.

Appendix 2: Miscellaneous Notes

Workshop on Designing and Adjusting Health Benefits Plans for Universal Health Coverage

International Decision Support Initiative with the University of Witwatersrand and the Center for Global Development

Monday, March 6th—Wednesday March, 8th
Health Benefits Package Training
Wits School of Public Health

Background:
Health benefits plans (HBP) are policy instruments used to set priorities for public spending on health. Defined as those "services, activities and goods reimbursed or directly provided by publicly funded statutory/mandatory insurance schemes or by national health services," HBP describe not only "what" is to be provided but also "to whom" and "in what circumstances", and should therefore be at the core of all publicly funded health care, and ultimately progress towards universal health coverage (UHC). HBP are not merely a list or a set of decisions, but should also be understood as an on-going process that shapes resource allocation and its outcomes now and in the future ("how 'who gets what' is decided").

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

In general, policymakers seek to understand the options available to decide what's in and what's out, and what other countries have done. On balance, is a HBP a good idea in our health system, or not? What methods and criteria should underpin decisions, and how should or can these criteria be balanced? How will the plan be kept up to date? What processes and institutions are needed? What

can be done about non-prioritized benefits? How will disputes in relation to the scope and content of the standard package be resolved? How should we manage the complex political economy and ethical terrain in which HBP decisions are taken and implemented? And finally, how can we make HBP work in practice, aligning with other enabling health system functions like payment? How do we know if HBP are delivering on the motivations that led to their creation and implementation?
This course—and associated book—will seek to provide some answers and framing of choices in response to these questions. The course itself is intended to be useful to a range of policymakers, technical staff, clinical leaders, donors and related audiences, but is mainly aimed at those charged with the task of designing, adjusting and evaluation a HBP over time. The course is intended for use by multi-country groups or single country groups; if the latter, the course will be tailored to the questions and challenges in that particular setting.

This version of the course—version 1.0—will be held in South Africa, with a focus on South African challenges and concerns. In South Africa, the Government's National Health Insurance (NHI) White Paper states that "a comprehensive package of personal health services" will be provided to beneficiaries, and further notes that "health service benefits will be provided and described in terms of the types of services to be provided at each level of care… including pharmacies and Emergency Medical Services." A list of disease control priorities is initially provided and an intention to link benefits with detailed treatment guidelines based on available evidence on cost-effectiveness will also be used to guide the delivery of the comprehensive health entitlements. To enact this intention, the Department of Health has set out terms of reference for the NHI work streams (11 December 2015) that includes the design of NHI Health Care Service Benefits building on best practice and establishing institutional arrangements for on-going revisions and establishment of permanent capacity to conduct health technology assessment.

Course objectives:

(i) Describe the role of health benefits plans in modern health systems, drawing practical policy and implementation lessons
(ii) Present a range of concrete examples from high- and middle-income countries
(iii) Discuss how health benefits plan-based policies can be operationalized considering resource and information constraints as well as context

Approach:

This four-day course is split into a one-day policy discussion and a three-day workshop and combines a core of formal teaching (divided into modules) with a highly participatory approach involving participant presentations, round tables and group work. The one-day policy dialogue is a South Africa-centered discussion among South African policymakers and leaders, while the 3-day workshop is more broadly focused around the HBP manuscript and will include 20-30 participants from institutions such as the WHO, CHAI, LSHTM, etc. along with ~10 iDSI partners. The course is based on a forthcoming book-resource on country experiences and emerging issues in the design and adjustment of health benefits plans, drawing on the latest evidence and a multidisciplinary team of experts from key organizations in the field.
The experiences of participants in practice will be central, with participants sharing their perspectives and developing next steps and recommendations for their own health system building

on the themes of the course. They will also be able to engage in dialogue with senior policymakers and scholars engaged in the issues, with the goal of two-way learning.
This will be the first version of the course, and is aimed at learning what will and won't work, what needs further development, and what other materials and input will be needed to enhance results, building from the idea of two-way learning. While the seminar will be focused on South Africa, the idea is to further develop the course and make it applicable to other country cases.

Module 1: Role of HBP in UHC • Framing the challenges and questions in South Africa, progress to date, next steps • Overview of rationale and policy cycle associated with HBP • Group work on how priority-setting (or HBP) works currently, who is involved and how decisions are taken on resource allocation, followed by reports back • Political economy of HBP – two country case studies followed by moderated roundtable
Module 2: Governance of the HBP • Principles of good governance for setting and adjusting HBP • Options for institutional arrangements to support the HBP policy • Fiscal and budgetary issues in developing HBP policy • Ethical, rights and legal issues in HBP policy • Group discussion and priorities/unanswered questions in South Africa
Module 3: Methods for the development and adjustment of HBP • Understanding the role of different methods in defining and adjusting the HBP, what choices need to be made • Principles and options underlying currently available methods (PBMA, CEA, HTA, ECEA, MCDA, etc.), contrasting actual practice and options, including transferability and use of external evidence, analyses and guidance • Group work, what has been used in your health system, what are issues, what are action areas
Module 4: Making it happen • What's needed, what are shortcuts and stop-gap measures, how to set priorities for priority-setting • What are and how to overcome common obstacles (limited capacity, budget and political will) illustrated using country experiences • Group work – what do we need to make it happen (better)

Faculty:
The course will involve a group of expert lecturers and facilitators from international organizations and centers of expertise and will be led by

- Amanda Glassman (Center for Global Development), Peter Smith (Imperial College, London), Ursula Giedion (Independent) as co-directors and instructors
    - Thematic speakers (TBC) may include: Tommy Wilkinson (Wits), Yot Teerawattananon (Thailand), Eduardo Gonzalez-Pier (Mexico), Alejandro Gaviria (Colombia), Carleigh Krubiner (Johns Hopkins University), Ricardo Bitran (Chile), Cheryl Cashin (Results for Development), Roberto Iunes (World Bank), among others

Attendees:

The International Decision Support Initiative (iDSI) is a mechanism to provide policymakers (at sub-national, national, regional and international levels) with coordinated support in priority-setting as a means to Universal Health Coverage (UHC). The initiative shares experiences, showcases lessons learned, and identifies practical ways to scale technical support for more systematic, fair and evidence informed priority-setting processes. Its interventions help to improve access to effective health interventions and the quality and efficiency of health care delivery, and to help elevate the value of priority setting as essential for attaining and sustaining UHC. iDSI is led by the UK's NICE International and Thailand's Health Intervention and Technology Assessment Program (HITAP) with core partners including PRICELESS SA at Wits University and the Centre for Global Development and in partnership with other government and non-government experts.

Health Benefits Design Group Work

Thailand:

Currently, Thailand doesn't have clarity on the budget threshold for new medicines or technologies to be included in the benefits package. So it is difficult for the committee to decide on what intervention will come into the benefits package. It is difficult to decide on the financial feasibility of interventions that can be included in the HBP. If there is clear evidence for incremental budget to be used for new intervention, then it is easier for the committee to decide on what is feasible or not feasible to include.

The UHC scheme in Thailand has 3 main goals: the first is health maximization for the population; the second is ensuring financial protection and equitable access as per the goals of the Government of Thailand; and the third is ensuring the sustainability of the UHC program, ensuring that it is a basic service not just for current but also future Thai generations.

NHSO will find researchers from independent research units (like HITAP) or university based HTA organizations to investigate the annual incremental budget to be used. This research evidence is needed to support future inclusion of new medicines and technologies.

Tanzania:

- Expect that the document will be finalized by May 2017
- Using health technology assessment but mostly for evidence
- Can share evidence with other countries
- Evidence-based approach

Ghana:

- The current situation has a general HBP that caters for tertiary, secondary healthcare
- But they have problems with it because they have outstanding areas for reimbursement for 11 months
- Reviewed in 2016 and the focus is now on PHC
- End of 2016 they had general elections and will see if the government accepts this
- They are hoping to have a process for HTA - need to build capacity of HTA working group, taking baby steps for HTA capacity building including negotiation
- Moving forward want to adopt best practices from all over the world
- Medicines selection has a provision for HTA so not a major problem

Discussion:

- For the health insurance, is this separate from the whole country?
    - Response: legally included, cannot easily maneuver this. There was a need to review the whole NHI. Need to check the issues they raised in terms of the whole stakeholder mapping. The package was aspirational so not able to manage it properly and now they have sustainability issues
    - Need to go back to Parliament and go back because there are new faces there, and now also in collaboration with iDSI partners

    - Also need to inform providers etc. and negotiate on this
    - There are also political and legal implications for this, need to check on the necessary inputs
- There are 3 separate documents?
    - There is a national social government document for the HBP

Ethiopia:

- Overview of current situation: there is a 20-year roadmap for development, now starting the health sector plan focusing on UHC. Finalizing the financing strategy for the upcoming 10 years. They don't need to redefine the goals, have it in their document. Regarding independent institutions, they have an independent research institute, providing different levels of data collection. They also have a health economics and financial team, which they see growing fairly fast similar to Asia and Europe. They are planning to have a multidisciplinary team, even though they have health economics, but need different representatives from different areas (e.g. including healthcare providers).
- Take home message: they will revise the currently existing benefits package. They have one from 2005 and needs to be revised, what should be included and not? And to define the threshold, similar to the one from Malawi, and include the budget linkage and equity.
- Key stakeholders, different levels: e.g. senior management of MOH, national bureaus in MOH, healthcare financing group, areas of healthcare financing, higher level advisory group, any will be covered by financing group. MOH and economic commission, Ministry of federal affairs, civil societies, etc.
- Different platforms as they have different powers. The MOH should conduct weekly meeting
- Regarding finance and human resource, based on existing situation, having national level of data (e.g. NHA, others)
- Additional international community support in the areas of HTA in most of SSA - CEA, benefits package revision

Discussion:

- For Francoise: they are interested in learning from other countries including the case of Malawi. There are various elements of consulting with right stakeholders, and very country specific steps. There is a whole program attached to that. Experience in Ghana, embedded in law. Learning from neighboring countries in Malawi would also be useful experiences, but what would that look like? Would those needed go to Malawi, or go to Ethiopia?
    - Response: start from what they have. Connect now, sharing materials, and then in the future, starting with what they have and perhaps in the future going to visit
    - Brainstorm on how GEAR can do that in an online way
    - Discuss on how we can learn from one another
- Worth reiterating about thresholds, whether that's actually a relevant thing, how should this be considered? Given the limitations on thresholds, how can this be implemented?

Indonesia:

- After more than 3 years of the social health insurance, on the one hand, the coverage increased rapidly
- Coverage is more than 174M people, more than 70% of population

- On the other hand, facing the budget problem, premium collection is not fit to the spending
- Review several high cost procedures and medicines, if high-cost, can take it out of their benefits package
- Committees composed of different agencies
- Key stakeholders, many are involved in this HTA activity from MOH and also from social security and health agency, there are some participants from BPJS
- The university, doctors' association, MOH, perhaps in the next time from parliament
- Although the benefits package is regulated by presidential decree, the Parliament may protest
- In terms of financial and human resources, they need to improve and strengthen the capacity of the member team of HTA
- They now sent a candidate to the MU for 3 year PhD studies
- And thinking on how to send more for capacity building
- Support from peers and international community: need external review from international expert and community, to look at what they have done for HTA in Indonesia and see how that is
- Working together with HITAP

Discussion:

- From Amanda: are you thinking about the HTAC (inside the MOH) - would it stay there, has it been influential on what to reimburse or not reimburse
    - May stay there because of regulation
    - but the team is composed of the hospitals, universities, etc.
    - Working independently but may in the future not be part of it
- Most studies done are in-house, the most recent development is to commission HTA work in universities. Can you share the experience on the challenges and factors that the university is thinking about? Developments on HTA in INA
    - Problem: there are so many medicines studies that need to be studied for included, and the budget limitation is there
    - They just finished the guideline, and this outlines that it can be done by the agent
    - They have 4 studies in 2017 - 2 studies will be done by the team under the MOH, and 2 studies will be done by universities
    - 2 funded by MOH, and 2 funded by the social security agency, so the user (BPJS Kesehatan or Centre for Healthcare Financing) starts funding the studies

Malawi:

- Separated the next steps to sub categories: purchaser provider payment mechanism and EML
- EML is supplied by the central procurement and only allowed to purchase from the list
- Regulating down that ladder and ensuring that the procedures are followed by providers
- No proper payment mechanism - service level agreements with the Christian Health Association, comprehensively in detail outlined based on the package
- Need to deal with decentralization, and districts have their plans and changing their mandate to include the EML and other national plans
- Districts need to also account for the different quantification needed - currently it is still historical budgeting and need to go back and see how they have allocated funding, and need to look at resource allocation formula

- See what needs to be provided to the package in the medium term - talking to donors and getting some sort of alignment
- Need a lot of political will to have these reimbursement mechanisms, and having a donor group
- Need to institutionalize in some way, housed in the department of planning and based on individual interest vs sustained work
- A lot of change and need to look at program based budgeting that need to be accounted for
- Like Zambia, all of these are taking place in terms of health sector strategic plan, once that plan is devised, outlining the next steps and make sure provision happens in reality

Discussion:

- What do you mean by input?
    - Budgeting is done on a line item based budgeting, looking at drug budgets plus normal budgets rather than output budgets
    - Start of reform looking at program budgets, charter not looking out for this, without going back to fundamentals of budgeting this is more of a façade

South Africa:

- Background: first phase of NHI coming to an end in 2017, and want to have a package of care for all levels, currently only have for primary care. They also have multiple guidelines for some interventions but none for others. The services want to be included in NHI - but not have the capacity to cover this financially
- They also want to have an evidence mechanism – how does the agency address point above
- The burden of disease should also be covered for each province
- The method on how to implement this, engagement between provinces and national department of health, different ways of having a service delivery platform.
- How can you make it that the public understands what NHI is and what is the benefit? Communication and increasing access in terms of reporting
- Establish HTA unit as soon as possible and can start soon with pharmaceutical products
- Can engage with countries with the same income level and can learn from those countries
- CHAI has started the process of creating an encyclopedia and cost
- Helps to inform the resources needed for these services

Discussion

- Incremental budget will decide what will be included in the benefits package
- In terms of reconciling the different schemes, is Thailand using some of the methodology for consolidating the scheme into one?
    - In the foreseeable future, the Thai government cannot cover. There is some mechanism that tries to do that – for drugs, there is only one pharmaceutical reimbursement list that is developed by the NLEM. All three schemes refer to this drug, except for CSMBS that allows them to get drugs outside this list. There is still room for CSMBS to get medicines outside this. Just this year, the government wanted to reconcile outside this, starting with health promotion, including the screenings, etc. There is now a committee trying to reconcile this, and there will be 1 year timeline. There is a lot of resistance to this, and CSMBS has more benefits and the only way to bring this down
    - Important for other countries with different schemes