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## Should Countries Set an Explicit Health Benefits Package? The Case of the English National Health Service



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### ABSTRACT

**Background:** A fundamental debate in the transition towards universal health coverage concerns whether to establish an explicit health benefits package to which all citizens are entitled, and the level of detail in which to specify that package. At one extreme, the treatments to be funded, and the circumstances in which patients qualify for the treatment, might be specified in great detail, and be entirely mandatory. This would make clinicians little more than automata, carrying out prescribed practice. At the other extreme, priorities may be expressed in very broad terms, with no compulsion or other incentives to encourage adherence. **Objectives:** The paper examines the arguments for and against setting an explicit benefits package, and discusses the circumstances in which increased detail in specification are most appropriate. **Methods:** The English National Health Service is used as a case study, based on institutional history, official documents and research literature. **Results:** Although the English NHS does not explicitly specify a health benefits package, it is in some respects establishing an ‘intelligent’ package, based on

instruments such as an essential medicines list, clinical guidelines, provider payment and performance reporting, which acknowledges gaps in evidence and variations in local resource constraints. **Conclusions:** Further moves towards a more explicit specification are likely to yield substantial benefits in most health systems. Considerations in determining the ‘hardness’ of benefits package specification might include the quality of information about the costs and benefits of treatments, the heterogeneity of patient needs and preferences, the financing regime in place, and the nature of supply side constraints.

**Keywords:** cost-effectiveness analysis, health benefits package, universal health coverage.

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### Introduction

The World Health Organization identifies three dimensions of policymaking choices as countries seek to implement universal health coverage (UHC): the groups in the population to be covered, the level of financial protection offered when seeking access to

services, and the range of services to be covered. Of these, the first two dimensions frequently offer little realistic scope for policy variation. Allowing access only to certain population subgroups contradicts the fundamental intent of universality. And imposing any level of user charges may exclude access for the poorest groups, as well as entail administrative complexity. Therefore, the central

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focus of policy will usually be the third dimension of the UHC design: the range of services to be made available, usually referred to as the health benefits package (HBP).

Many high-income countries have sought to maintain packages that are quite comprehensive, in the sense that most clinically accepted interventions have been included [1]. In contrast, low- and middle-income countries with slender resources have been forced to confront the issue of which interventions or services to include in their benefits package [2]. Sometimes, as, for example, in the case of Chile [3] or Mexico [4], this problem has been addressed directly, and a carefully circumscribed package has been explicitly defined. More often, however, the package has been developed piecemeal and implicitly, as, for example, in India [5].

Numerous techniques and processes have been adopted for selecting the benefits package [6]. Nevertheless, whatever the resources available, policymakers will usually wish to maximize the effectiveness of their UHC policy, in the form of maximizing the “value” (however defined) of the health services purchased with the limited publicly funded budget. Economists have advocated the use of cost-effectiveness analysis (CEA) as making this principle operational, on the assumption that the objective to be maximized is health gain. Although the application of the cost-effectiveness criterion suffers from some theoretical limitations, it has enjoyed widespread acceptance as a reasonable principle for prioritizing the use of scarce health service resources [7].

CEA should therefore be an important tool for determining which health services to fund as countries seek to implement UHC. Nevertheless, implementation of the cost-effectiveness criterion for setting the HBP is seriously hampered by major practical limitations, such as the following:

1. Lack of adequate data for many, if not most, interventions;
2. System constraints that preclude immediate changes in service delivery;
3. Political constraints that circumscribe many choices; and
4. Lack of adequate capacity for assembling and synthesizing relevant analytic material [8].

As a result, most benefits packages have been developed in an ad-hoc fashion, sometimes shaped by CEA, but often tempered by practicality and inertia.

The English National Health Service (NHS) is an archetypal central planning approach toward UHC. Furthermore, it has established a renowned agency for assessing new and existing treatments, in the form of the National Institute for Health and Care Excellence (NICE). Yet, notwithstanding the apparent clarity of the NICE terms of reference and the technical resources at its disposal, it has focused mainly on the evaluation of new technologies, and it can be argued that NICE has had only a modest impact on the total range of services actually made available to NHS patients. The English approach toward setting the benefits package is therefore of particular interest as a basis for discussing the tensions and constraints that arise when seeking to determine what health treatments are to be made available [9].

This article examines the extent to which the English NHS has an explicit HBP. It first sets out the arguments for and against such explicitness. It then specifically examines the role of CEA in guiding the creation of the package. A short outline of the English health system then follows, with an assessment of the extent to which that system yields an explicit statement of entitlements. The article then concludes with some general observations on setting the HBP.

## Arguments for and against Setting an Explicit HBP

As documented by Glassman et al. [10], there are numerous well-rehearsed arguments in favor of setting an explicit HBP to which all beneficiaries are entitled:

1. It creates *explicit entitlements* for patients, whose access to services might otherwise be largely determined by clinical professionals, with the consequent potential for arbitrary variations in access.
2. It helps to identify *whether funds are being spent wisely* on services that create the maximum benefit for the society.
3. By specifying the services to be delivered, it facilitates important *resource allocation decisions*, such as regional funding allocations, and other planning functions, creating a precondition for reducing variations in care and outcomes.
4. It facilitates orderly *adherence to budget limits*, which might otherwise be attained only through arbitrary restrictions on access and services.
5. It reduces the risk that providers will require *informal payments* from patients to secure access to high-value services.
6. The entitlements created empower *poor and marginalized groups*, who cannot be made aware of any specific entitlement without an explicit HBP.
7. It creates the preconditions for a market in *complementary health insurance* for services not covered, with a number of potential benefits for the health system as a whole.

It is important to distinguish between explicitness in stating the contents of the benefits package and consistency and rigor in selecting the contents. It is quite conceivable that a package may be made explicit, but the process for selecting the contents is opaque and inconsistent. Some of the aforementioned virtues of an explicit package arise whatever may be the selection process. Nevertheless, most can have full effect only if the package is selected using consistent application of an explicit set of criteria.

Notwithstanding the powerful reasons for developing an explicit benefits package, and basing it on consistent stated criteria, there are also reasons for caution in pursuing an explicitly delineated package:

1. There are very significant *practical difficulties of specifying a package* in enough detail to have an impact on clinicians. Although it may be feasible to make broad statements regarding the services to be delivered, it may be impractical to specify the circumstances in which specific treatments may be funded. This may be because of a lack of suitable evidence and analytic capacity, a lack of adequate information systems or funding mechanisms, or a lack of detailed clinical guidelines on what constitutes best care.
2. A closely defined package may *inhibit innovation*, especially if it is based on treatments to be delivered rather than on disease categories. If the package is not constantly reviewed and updated, there is a risk that it will reflect outdated approaches to care, and ignore new, more efficient treatments or modes of delivering care, and inhibit take-up of those new approaches.
3. In the same vein, the package may *inhibit warranted variations in treatment* that reflect patients' circumstances or preferences. The contents of any package will be based on broad average responses to treatment in the population at risk. Although it is important that all treatments should be cost-effective, there will often be circumstances in which clinical judgment may suggest departures from usual treatment for specific patients that improve cost-effectiveness. In principle, any package should be flexible enough to accommodate such departures.

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