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TECHNICAL MEETING REPORT

STRENGTHENING NCD SERVICE DELIVERY THROUGH UHC BENEFIT PACKAGE

14-15 JULY 2020, GENEVA, SWITZERLAND

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Strengthening NCD service delivery through UHC benefit package: technical meeting report, Geneva, Switzerland, 14-15 July 2020

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ABBREVIATIONS

CEA	Cost-effectiveness analyses
EPHS	Essential Package of Health Services
EHSP	Essential Health Service Package
EUHC	Essential universal health coverage
GAP	Global Action Plan
HBP	Health benefit package
HTA	Health technology assessment
LMICs	Low and middle-income countries
NCD	Noncommunicable disease
NHS	National Health Service
OOP	Out of pocket payment
PBF	Performance-based financing
PHC	Primary health care
PLWNCD	People living with noncommunicable diseases
R/UHC-PBP	Regional UHC Public Benefit Package
SSB	Sugar-sweetened beverage
WHO	World Health Organization

GLOSSARY

DATA SPACE

Data space refers to the complete set of available data from different sources that pertain to a given topic.

EQUITY

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *Health inequities* therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.

FISCAL SPACE FOR HEALTH

Fiscal space is the set of available financial resources within the government that can be used to pay for health.

HEALTH TECHNOLOGY ASSESSMENT (HTA)

HTA is a systematic and multidisciplinary evaluation of the properties, effects, and/or impacts of a given health technology or intervention. HTA reviews the technology for social, economic, organizational and/or ethical impacts to inform policy decision-making.

IMPLICIT RATIONING

Implicit rationing refers to non-transparent mechanisms of service rationing that occur when promised benefits exceed the resources that are actually available. In this situation, services and medicines may become unavailable, resulting in the use of private resources by patients making payments in order to get access to them.

NONCOMMUNICABLE DISEASES (NCDS)

Noncommunicable diseases (NCDs) are conditions that are not passed from person-to-person. The four main types of NCDs are: cardiovascular diseases (such as heart attack and stroke); cancers; chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma); and diabetes. Most NCDs are chronic, of long duration, and progress slowly.

OUT-OF-POCKET (OOP) PAYMENTS

Out-of-pocket (OOP) payments are made by individual patients directly to health care providers at the time of service provision. This excludes prepayment for health services (for example, in the form of taxes or specific insurance premiums or contributions) and net of any reimbursements to the individual.

PATIENT PATHWAY

The patient pathway is the steps and points through which an individual seeks and receives diagnoses, treatments and follow-up from a health system.

POLICY DIALOGUE SPACE

Policy dialogue space refers to the full set of opportunities and systems utilized to engage health policy makers and other stakeholders in designing and assessing a set of policy options.

POLITICAL DECISION SPACE

The political decision space describes the amount and type of authority that decision makers can wield and the range of possible choices amongst which they can choose.

UNIVERSAL HEALTH COVERAGE (UHC)

Universal health coverage (UHC) is defined as when: "all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective, quality and accessible medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable, and marginalized segments of the population."[1]

UNIVERSAL HEALTH COVERAGE PRIORITY BENEFIT PACKAGE (UHC-PBP)

A set of publicly-financed, evidence-based, prioritized individual and population-based health interventions that has been defined throuogh a deliberative process and which accounts for people's health needs, a country's economic reality, and societal preferences. The UHC-PBP consists of both health services and programs and intersectoral actions and fiscal policies.

ZERO-BASED BUDGETING[2]

A method of planning budgets that requires calculating and justifying all expenses for the coming period based on needs and costs, regardless of how much was previously allocated for them.

Sources: World Health Organization (www.who.int), World Bank (www.worldbank.org)

EXECUTIVE SUMMARY

All countries, regardless of economic or political status, face challenges in providing their populations with Universal Health Coverage (UHC) and accessible, high-quality health services. The increasing prevalence of noncommunicable diseases (NCDs) is a key facet of this challenge. Meeting global commitments to expand UHC service coverage is unlikely – unless concerted action on NCD occurs. Ensuring that NCDs are incorporated into the process of health benefit package design is necessary to achieve UHC and sustainable financing to prevent and treat NCDs.[3]

To contribute to the development of a coordinated approach to this fundamental task, a Strategic Roundtable on Strengthening NCD Service Delivery through UHC Benefit Package was convened on 14-15 July, 2020. The Roundtable brought together health experts from Ministries of Health, the World Health Organization (WHO) and other partners to review and share experiences on the inclusion and prioritization of NCDs in health benefit packages. The meeting sought to align different health intervention listings and approaches to the design of health benefit packages. It produced key conclusions on the issues and a provisional Roadmap for developing meaningful support for countries committed to addressing NCDs through UHC benefit packages.

Most countries are not able to provide all essential health services to their entire populations, due to factors of affordability and access. Therefore, prioritization of health services for coverage through explicit rationing is a key mechanism to ensure equity, fairness, effectiveness and financial protection. The process of national prioritization of services in health benefit packages is complex and reflects collective choice. The meeting reviewed the WHO "3-Ds Priority-setting and Decision-making Framework," which provides a structured approach to help countries do this. Two other tools, the WHO UHC Compendium and the Diseases Control Priorities 3 (DCP3), provide model listings of essential health services, collating the available data on the efficacy, cost, cost-effectiveness of health interventions, and categorizing them by priority level. Countries can use and adapt the tools according to their local contexts.

During the Roundtable, participants committed to fill NCD data gaps by gathering concrete evidence of cost-effectiveness and economic gains of investing in NCDs, and improving facility based and clinical data for NCDs. Experts prioritized the drive toward country-owned processes, with a focus on strengthening local capacity for benefit package design. Meeting participants also stressed the need for more high-level advocacy to secure political commitments and leadership on benefit package development, and noted the importance of diffusing common misconceptions about NCD services, such as that they are all expensive and unsustainable. The meeting further affirmed the need for a health system perspective and multisectoral and integrated approaches to improve NCD service coverage on the path toward UHC.

The Roundtable concluded with the creation of a Roadmap of strategic steps towards development of global guidance for inclusion of NCDs in UHC benefit packages, including regional and national adaptation of intervention listings and country implementation and enforcement. Meeting participants agreed on the importance of starting to work with countries without delay. Throughout the Roundtable, participants noted that the ongoing COVID-19 pandemic has both exacerbated and highlighted the relevance and urgency of addressing NCDs in UHC.

1. INTRODUCTION

Under Sustainable Development Goal (SDG) target 3.4, the World Health Organization (WHO) and its Member States committed to reduce premature mortality from noncommunicable diseases (NCDs), which were responsible for 71% of all deaths globally in 2016.[4] Another cornerstone of the SDG Agenda is achieving universal health coverage (UHC); SDG target 3.8 aims to "achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all." However, the COVID-19 epidemic has created major new challenges to achieving these (and other) SDGs. COVID-19 has a deadly interplay with NCDs; further, it has laid bare the fragility of health systems.

The current epidemic has interfered with health systems' existing capacity to respond to NCDs by disrupting essential health care services for NCDs and because attention to NCDs was not included in the initial humanitarian response.[5] There is a critical need to make NCDs, as well as mental health conditions, essential components of UHC and accessible health services for all. Doing so requires including them in the Global NCD Action Plan 2013-2020[2], and the WHO Independent High-Level Commission on NCDs, and the agenda for Building Back Better post-COVID-19.[3]

Progress on ensuring access to NCD services is lagging and concerted efforts are required to strengthen health systems' capacity to provide health care for people with NCDs. Countries' experiences of implementing UHC have shown wide gaps in coverage for NCD services. Given the high share of disease burden, morbidity and mortality caused by NCDs, these gaps demand attention.[4] In order to firmly place NCDs within the UHC agenda, governments should expand coverage for health promotion and NCD prevention and management in the entitlements included in a UHC public benefits package (UHC-PBP).[5]

Together with partners, WHO has worked to define an explicit methodology for UHC benefit package design, with the objective of supporting countries in developing and implementing benefit packages. Prioritization and inclusion of comprehensive cost-effective NCD interventions in this process at country level is critical, particularly given the usual gap in coverage for NCDs.

In the Political Declaration on UHC from 2019, governments committed to "progressively cover 1 billion additional people by 2023 with essential health services and affordable essential medicines, by 2023."[6] Fulfilling this commitment requires progressively embedding and expanding coverage for NCD prevention and management within UHC entitlements included in a UHC health benefits package. The translation of NCD plans toward prioritization of services, with explicit definitions of benefit entitlements in essential or benefit packages, is needed.

Given the global mandates, as well as increasing demand from Member States for guidance on how to design UHC benefit packages with attention to NCD services, WHO in Geneva organized an expert technical meeting that was held virtually on 14–15 July 2020.

THE OBJECTIVES OF THE MEETING WERE TO:

- Review and share experiences and current work in health system strengthening for NCDs, the UHC Compendium, and UHC Benefit Packages
- Discuss strategic alignment of different initiatives and approaches to the design of priority listing of services and development and implementation of UHC Benefit Packages with a focus on NCDs
- Discuss a roadmap to include NCDs into the UHC Benefit Package support provided to countries

The expected output of the technical meeting was to develop a Roadmap for the development and implementation of global guidance on national health benefit package design that ensures adequate representation of NCD-specific issues, and for supporting countries in implementation; this is presented in Annex 1.

The WHO secretariat for the event consisted of staff from the Departments of Noncommunicable Diseases and Health Systems Governance and Financing. The meeting convened global experts in public health, health financing and economics with experience in prioritization of health services and UHC benefit package design and implementation. The full list of participants is included in Annex 2. The group included country experts from Ukraine and Ethiopia, as well as WHO staff with experience in the Eastern Mediterranean Region and European Region.

The meeting was conducted virtually and consisted of panel presentations and discussions on several relevant topics, including the rationale, design, prioritization and implementation of UHC benefit packages, financing options for NCD services, and various available tools. Country experiences in design and implementation of UHC Benefit packages were shared. Plenary discussions addressed these topics and possible actions in the development of global guidance and a roadmap for country implementation. The full programme is provided in Annex 3.

This report follows the structure of the meeting, summarizing key messages presented by speakers.

2. OVERVIEW OF HEALTH SYSTEM RESPONSE TO NCD

Dr Ren Minghui, WHO Assistant Director-General, UHC/Communicable Diseases & NCDs, opened the meeting with a summary of the trajectory of global attention to NCDs. Dr Minghui noted that political momentum was generated by a High-level Meeting on NCDs in 2011, but was then offset in the following years by interference in health policy-making by vested interest groups, lack of domestic funding, and insufficient Official Development Assistance to establish the minimal critical capacity, mechanisms and mandates needed to pursue change in low and middle-income countries (LMICs). As a result, NCDs represent the largest and most underfunded public health issue globally – and the area where the most lives could be saved.[7] For example, the 2019 Global Monitoring Report for UHC reported that, since 2000, no World Bank income group of countries has demonstrated progress toward the Service Coverage Index for NCD.[8] Further, the most frequently received request to WHO for technical assistance in the 2019-20 biennium was for support to integrate NCDs into primary health care (PHC) and UHC. Finally, Dr Minghui noted the deadly interplay between the COVID-19 pandemic and NCDs, which has revealed existing challenges to the entire world and exemplified the immense need for change.

Dr Bente Mikkelsen, Director, WHO NCD Department, then presented an overview of health systems' responses to NCDs. NCDs are responsible for 15 million deaths per year in individuals aged 30-70 years old, and comprise 85% of deaths in the developing world, forming one of the major challenges for development in the 21st4 century. Global commitments to address the NCD burden were iterated during the UN General Assemblies in 2011, 2014, 2015, and 2018.[9,10,11,12] The Astana Declaration on PHC and the UN High Level Political Declaration on UHC have been crucial in setting a mandate to strengthen health systems for delivery of adequate NCD services.[13] However, despite progress, the health care needs of people living with NCDs (PLWNCDs) are still not being met. Further, disparities among rich and poor countries expose significant deficiencies in ensuring NCD services for all.

Dr Mikkelsen again noted that COVID-19 has revealed weaknesses in populations' health status, the social fabric, and health systems. The coinciding of the COVID-19 pandemic and NCD epidemic has highlighted and amplified chronic underinvestment in the prevention, screening, treatment and rehabilitation for NCDs – and the results of disrupting those services that do exist. The world is at a critical juncture and a forward-looking strategy that includes NCDs is required to "build back better" and to reach the SDG 3.4 target for reducing premature mortality from NCDs.

Despite considerable progress, the momentum of change has slowed since 2010, with major NCDs such as diabetes showing a 5% increase in premature mortality. PLWNCDs are especially vulnerable to becoming severely ill or dying from COVID-19. Many countries' health systems were not able to maintain regular services while responding to the challenges created by the COVID-19 pandemic. In particular, rehabilitation services faced partial or full disruptions, and up to 60% of hypertension and diabetes services were disrupted[5]. This was also true for urgent dental treatments, and treatment for cardiovascular diseases and other NCDs. A WHO rapid assessment did show that 75% of Ministries of Health are collecting data on NCD-related co-morbidities for COVID-19.[5] This data can be leveraged to better prepare for future emergencies.

Many data gaps have been exposed, including inadequate facility-based data and clinical data on NCDs. Data and treatment gaps alike accentuate the need to strengthen health systems, so that a patient with, for example, hypertension can get screened to be made aware of his/her status and seek proper care. There is general agreement that it is critical to include NCDs in PHC and UHC benefit packages; in order to do so, policy-makers must refine domestic and international financing patterns and explore innovative solutions. WHO is developing and advancing several products and technical support options to address these gaps, including through cross-cutting work on the health system building blocks (governance, financing, service delivery, medicines and technology, health workforce and health information systems). Firmly placing NCDs – and related conditions such as mental health, oral health, sensory functions, disability and rehabilitation – at the forefront is essential to tackling immense preventable burdens of morbidity and mortality.

3. PRIORITIZATION OF HEALTH SERVICES

UHC has three main objectives: 1) financial protection from health care related costs; 2) population coverage to achieve equitable access to care; and 3) appropriate breadth of health services included in the benefit package. Governments rely on regulation, policy coordination, health financing and service provision in setting the agenda for UHC, including coverage of NCDs. The path to UHC in any given country must be dictated by the local context, respond to social values, and understand the health system's capacity – these conditions vary across countries.

Attaining UHC begins with a political choice and requires leadership and commitment to design policies and mobilize resources according to country context and need. Political leaders and the health workforce must work to build confidence in the health system by delivering continuous, quality services over time. While financing services is a core challenge, ensuring delivery of these services is equally important. The path towards UHC demands continuous engagement to bridge the health care access gaps, recognizing the inevitability of trade-offs along the way.

UHC in some form is technically and financially feasible for every country, and WHO and partners are eager to provide technical support and instruments to assist countries to strategically plan, implement and enforce the delivery of health services, including those for NCDs. Two key tools, the UHC Compendium[14] and a list of Best Buys for NCDs[15], already exist to support countries in defining essential health services for NCDs.

Most countries have a narrow fiscal space for health. As a result, achieving UHC may require either: an overall increase in health allocations; or, prioritization of an Essential Package of Health Services (EPHS) according to the available fiscal space for immediate implementation and possible expansion if the fiscal space increases; or, re-adjustment of the EPHS by introducing co-payments. Additional funding for health can be generated from economic growth, donor funding, revenues from taxation of unhealthy products, or earmarking and innovative financing. However, a realistic path to secure funds for health is ultimately through the reprioritization of government funding; this may require initiating an in-depth fiscal space analysis, avoiding generic arguments to actors outside of health, linking to an investment plan, gathering concrete evidence of the cost-effectiveness and economic gains of investing in health, and engaging in high level advocacy.

3.1 RATIONING

Dr Agnes Soucat, WHO's Director of Health Systems Governance and Finance, discussed the concept of rationing, which occurs when a scarcity of resources provokes limits on public spending on health care. Rationing is a political mechanism that may be more or less explicitly applied. Most health systems, particularly in LMICs, rely on implicit rationing, in which the supply and distribution of available services is determined by the public's ability to pay directly. Implicit rationing often results in an inequitable and inefficient health system.

The alternative to implicit rationing is explicit rationing, in which the health system determines and informs patients which services are accessible, and defines rules associated with that access. Examples of explicit rationing techniques include defining a minimum EPHS or a national Essential Medicines List, setting rates for co-payment at the point of use,

gate keeping (an arrangement between primary care providers and specialists which involves a generalist (primary care doctor, family medicine doctor, general practitioner, etc.) who controls access to specialist care and coordinates care for patients [16]) or establishing a waiting list for selective surgery. Explicit rationing involves greater transparency and thus creates trust in the system. Explicit rationing usually utilizes a set of institutions and decision-making mechanisms to manage the scarcity of resources. Policy-makers and other relevant stakeholders should consciously and purposefully engage these institutions and mechanisms in three stages of policy implementation: design, roll-out, and enforcement. Four attributes for explicit rationing for UHC include:

1. Existence of a priority-setting process with explicit criteria
2. Clear entitlements and obligations for the beneficiaries
3. Defined benefits that align with available revenues, health services and mechanisms to allocate funds to providers (i.e. strategic purchasing)
4. Rationing mechanisms put explicit limits on out-of-pocket (OOP) payments by patients and enhance access for vulnerable/priority groups

Table 1 summarizes some key issues involved in explicit rationing by mapping the four attributes of explicit rationing to the three steps (design, roll-out and enforcement). The table also shows the level of complexity of each aspect.

TABLE 1. MAPPING KEY ISSUES IN EACH PHASE OF EXPLICIT RATIONING

Attribute of explicit rationing	Design	Roll-out	Enforcement
Existence of a priority setting process with explicit criteria	E.g., use of HTA to determine value of a given intervention	Takes time to establish a whole structure with sufficient capacity	Use techniques such as cost-effectiveness analysis (CEA), to ensure transparency and stakeholder participation in decision-making
Clear entitlements and obligations for households	Either a "positive list" defining all services that are included, or a "negative list" in which all services are covered except for those specified in the negative list; co-payment rates, patient pathway.	Communication, financial computation	Communication, accountability mechanisms
Defined benefits aligned with available revenues, health services, and mechanisms to allocate funds to providers (i.e. purchasing)	Strategic plan, budget and payment mechanisms	Training, medicines ordering, adaptation of the health information system, etc.	Through funding health system building blocks, (e.g. PBF)
Rationing mechanisms with explicit limits on OOP payments by patients and enhanced access for vulnerable/priority groups	Eligibility criteria and specific health financing schemes	Training, data system, funding, contracts, etc.	Monitoring, reward and sanction, transparency, empowerment, etc.

Note: the darker the box, the greater the complexity

KEY MESSAGES ON HEALTH SERVICE RATIONING:

- Resources are limited and needs are numerous, leading to the occurrence of rationing. Explicit rationing is the key to UHC, while implicit rationing undermines UHC.
- Countries should seek to establish an optimal combination of explicit rationing mechanisms for UHC through three steps: design, roll-out and enforcement. If these steps are not managed well, implicit rationing will result.
- Establishing a positive list of services available for patients with a given disease and assessing its budgetary affordability is not enough. Health economics analyses contribute at several levels, including in the design and enforcement of adequate institutional arrangements.
- Embracing a health system perspective and strengthening each health system building block is essential.

4. UHC BENEFIT PACKAGES

4.1 PRINCIPLES OF UHC BENEFIT PACKAGES

The scarcity of resources requires priority setting in health care. A large set of services and technologies exist that could be added to the list of health care provided to the public in any country. However, all countries have limits to what they can afford to purchase. Creating collective arrangements for health financing is a recent phenomenon, and they require decisions about which technologies or services will be offered (including which will be defunded to create fiscal space for newly approved services based on emerging evidence and practice). Deciding how to determine which services are chosen for support requires each society to conduct collective conversations on prioritizing spending from the "public purse."

Dr Agnes Soucat introduced core aspects of essential health services and benefit packages as an integral part of financing for UHC. Benefit packages are a set of public instruments that govern which services or products can be paid for with collective money; benefit packages are an alternative to use of the market rule, which allows individuals to demand a service or product. Most contemporary societies have chosen to use social health insurance, a collective route to develop institutional arrangements to fund services. This approach is based on a political imperative that promotes social cohesion, building toward more sophisticated social contracts. With the development of more effective health interventions, the question of how to allocate spending from the public purse has become ever more complex.

THERE ARE EIGHT KEY PRINCIPLES IN THE DESIGN OF ESSENTIAL HEALTH BENEFIT PACKAGES:

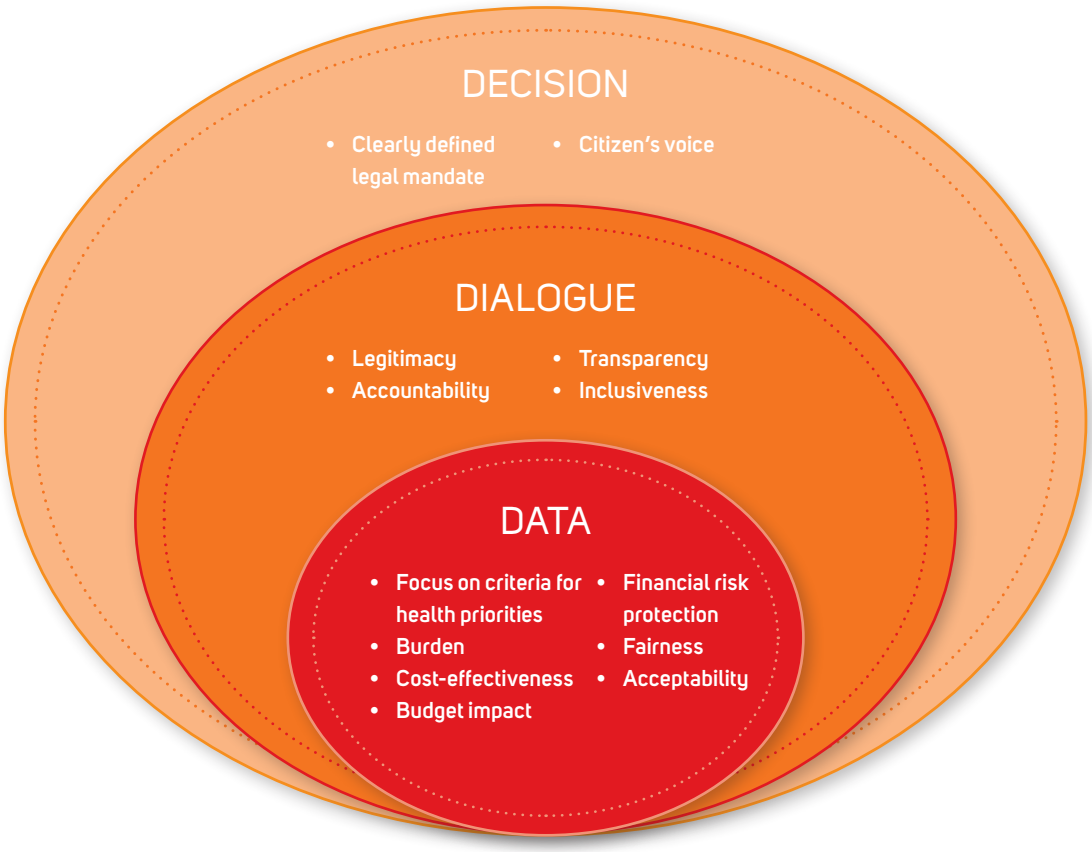
1. Essential benefit package design should be **impartial, aiming for universality**.
2. Essential benefit package design should be **democratic and inclusive, with public involvement**, including from disadvantaged populations.
3. Essential benefit package design should be based on **national values** and clearly defined criteria.
4. Essential benefit package design should **be data driven and evidence-based**, including revisions in light of new evidence.
5. Essential benefit package design should respect the difference between data analysis, deliberative dialogue and decision.
6. Essential benefit package design should be **linked to robust financing mechanisms**.
7. Essential benefit package design should include **robust service delivery mechanisms** that can promote quality care.
8. Essential benefit package design should be **open and transparent** in all steps of the process and decisions should be clearly communicated.

4.2 UHC BENEFIT PACKAGE DESIGN

The document, "Making fair choices on the path to universal health coverage"[17] sharply focuses on equity as a guiding principle to steer countries toward adopting entitlements that will ultimately reach their entire populations. Investing in common and public goods, which are equitable by definition, is a critical, yet often overlooked, "step zero." The COVID-19 pandemic has highlighted the importance of sufficient investment in population-based services.

The WHO's "3-D priority setting and decision-making framework"[18] provides a structured approach to UHC benefit package design. As shown in Figure 1, the framework focuses on data, dialogue and decision. The process aims to reach a collective decision on which health services should be included in a UHC benefit package; it is designed to be evidence-based, transparent and fair.

Figure 1. The WHO 3-D priority setting and decision-making framework



An inclusive and transparent decision-making process is fundamental to the prioritization and inclusion of health services in health benefit packages. Selection criteria should be based on the values of the population served, with methods to weigh different services against each other to identify interventions with clear value for money.

CAPTURING DATA AND EVIDENCE

The data necessary to inform the UHC benefit package design includes population averages of mortality and morbidity to help define the burden of disease, including magnitude, severity, urgency and perception. Data on other issues – particularly ageing, end of life and quality of life measures with relevance to NCDs – is also needed to objectively assess which core health services will best address the needs of a given population.

Cost-effectiveness analyses (CEA) and other measures of value-for-money help establish whether a health intervention represents good value when compared with alternative uses of the same resources, while budget impact analyses explore whether the cost of an intervention is feasible and sustainable. These data must also account for the common costs of shared health systems components, which are often overlooked within the unit cost of individual services.

WHO CHOICE[19] and other similar tools are available to help generate national cost-effectiveness data to support the health benefit package development process and identify potential efficiency gains in the service package. The WHO OneHealth tool[20] is used for integrated health systems planning by considering costs within an envelope of financial affordability, including the cost of scaling up the health system and delivering care at different levels with a number of diseases programmes, including NCDs. This tool also includes impact models to measure how many lives would be saved and how many additional years would be lived in good health if selected interventions are implemented.

Collection and use of more data on financial risk protection, affordability and feasibility should be considered. The availability of data alone is not enough; an investment needs to be made in institutionalizing the data space at country level to enable local academic institutions and experts to produce their own country-level data and guidance.

PARTICIPATORY POLICY DIALOGUE

Policy dialogue involves the appraisal of relevant data and other knowledge. An open policy dialogue space facilitates the legitimacy, accountability, transparency and inclusiveness of the process of UHC benefit package design by enabling a bottom-up approach steered by a collective societal dialogue. An extensive consultation process allows policy-makers to reconcile the views of experts and the citizens' voices to ensure legitimacy as they integrate various perspectives into a political decision space with a clearly defined legal mandate. Noteworthy examples of countries' participatory policy dialogues include the National Health Assembly process in Thailand[21] and the mechanism used in the National Institute for Health and Care Excellence in the UK to inform decision-making for the National Health Service.[22]

Bringing together a diverse group of stakeholders is a fundamental element of open policy dialogue. A heterogeneous group that includes people of all ages and genders, including representatives from the most disadvantaged communities, with different views and perceptions helps facilitate a balanced dialogue process. Tunisia's example illustrates the incredibly strong sense of responsibility among its citizens, who continue to participate in societal dialogue despite economic and social crisis and the additional strain placed by COVID-19. In stark comparison, while the United States of America has advanced capacity in the data and decision spaces, tensions at the level of the social contract generate major issues in the health care dialogue.

DECISION-MAKING THROUGH CITIZENS' CHOICE

Decision-making on UHC benefit packages is a political function ultimately taken (in most countries) by the Minister of Health. This ensures that the decision-making is independent of the mechanisms of data collection and dialogue which, although deliberative, often meet with transparency and conflict-of-interest challenges. A clearly defined legal framework enables the government to assign decision-making roles and responsibilities across institutions. Further, common agreement on interpretation of data and values is central to a strong decision-making process. An organized political structure, such as a National Health Assembly used for setting overarching priorities in health, is needed to generate political decision-making that reflects a collective process.

The potential effects of health interventions can be determined through health technology assessments (HTAs), which provide a systematic approach to evaluation of the properties and consequences of different technologies, interventions, and health system mechanisms. HTA is a multidisciplinary process to evaluate the social, economic, organizational and ethical issues of a health intervention or health technology in order to inform policy decision-making. Once key decisions are made, countries can progress to linking the health benefit package to the allocation of public funding through the budgetary process.

5. TOOLS FOR UHC BENEFIT PACKAGE DESIGN

Countries engaging in the prioritization of health services in a health benefit package have several valuable starting points at their disposal. The WHO UHC Compendium, Disease Control Priorities III (DCP3), and regional prioritization exercises provide countries with a reference list of interventions to begin the prioritization process.

5.1 THE WHO UHC COMPENDIUM

Dr Melanie Bertram highlighted that the WHO UHC Compendium[4] operates as a "one-stop shop" for countries beginning the process of health benefit package design and decision-making. The Compendium brings together evidence on the health care services and public health interventions that are currently delivered in countries, including data on efficacy, cost, cost-effectiveness, equity and financial risk protection. The Compendium was created through an extensive process of data collection, harmonization and standardization that was led by an internal WHO working group. The process resulted in an initial list of around 700 interventions, with forthcoming additions. The UHC Compendium provides options for different packages and links them to health system requirements.

RELATED STREAMS OF WORK AT WHO TO SUPPORT COUNTRIES IN DEVELOPING AND IMPLEMENTING BENEFIT PACKAGES INCLUDE:

- Country-level modelling tools to assess costs, health impacts and health system constraints associated with providing specific service packages
- Guidance on the benefit package process
- Guidance on service packages and health workforce requirements
- Regional adaptations, including packages focused on key settings such as conflict/emergency

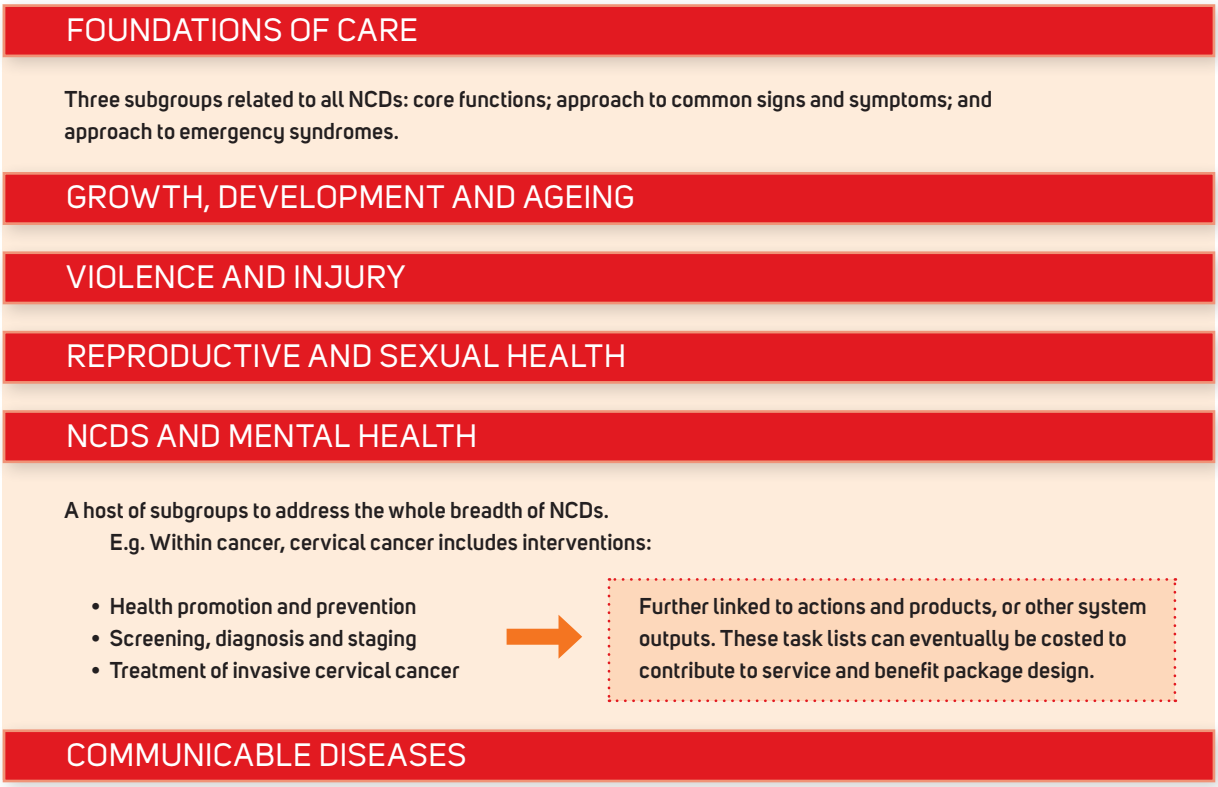
This tool empowers countries with relevant data, including all intervention guidelines, WHO Model Lists of Essential Medicines (EML), lists of medical devices and diagnostics, health workforce requirements and standardized cost-effectiveness tools, a service planning tool, and material resource (equipment supplies and medication) planning to aid in prioritization of interventions. Most interventions included in the UHC Compendium have evidence of high-level efficacy and some data on cost. The UHC Compendium's interactive data portal features a keyword search on disease areas, health programmes, and service delivery platforms, among others, and a dashboard that outlines the necessary information.

To facilitate country decision-making processes, interventions are categorized using a traffic light system. High priority interventions that should definitely be included in a benefit package are labelled in green. These include NCD "best

buys" that are low cost, highly cost-effective and easy to implement. Red interventions either do not match the burden of disease in the country, are very high cost compared to what the country currently spends on health services, or are unnecessary according to country context. The remaining orange interventions become the main target of the decision-making process, requiring dialogue toward a collective choice on whether these interventions should be progressively included in the health benefit package.

Dr John Fogarty shared examples of use of the UHC Compendium, noting that it is geared to help countries create people-centred packages based on a patient pathway. That is, it employs a structure that meets different use cases of patients presenting at a health facility. The UHC Compendium's clinical frame, as shown in Figure 2, comprises six categories (one of which is NCDs and mental health), each with sub-categories, actions and products.

Figure 2. UHC Compendium clinical frame



Cross-sectoral policy options, many of which impact NCDs, comprise a separate category. These are policies that are not delivered to individuals at the clinical level but rely on contributions from different ministries and often take place at the population level. These include tobacco taxation, sodium reduction policies, promotion of fruit and vegetable intake and physical activity campaigns.

5.2 DISEASE CONTROL PRIORITIES III (DCP3)

Dr. Ala Alwan, emeritus EMRO Regional Director, described the Disease Control Priorities (DCP) publication, which provides a periodic review of evidence on cost-effective interventions to address the burden of disease in low-resource settings. The third edition, DCP3[23], comprises nine published volumes. The DCP3 takes a range of different topic areas, several of which were added in 2016 following the endorsement of the UHC agenda by the UN (in the form of SDG target 3.8) and a workshop organized by the Bill and Melinda Gates foundation. DCP3 contains 21 sets of policy recommendations that are developed and reviewed based on a set of criteria. It offers two kinds of recommendations: those related to services delivered within the health care system; and, other health promoting interventions or policies implemented by non-health sectors.

The country translation phase of DCP3 began in 2018. Its key objectives were to support pilots in priority setting and developing and implementing health benefit packages (HBPs) in selected countries in the context of UHC. Pilot countries were supported to build capacity in economic evaluation, priority setting, and setting and updating HBPs. They also contributed to updating technical guidance to support other LMICs in the design and revision of HBPs. Current efforts are focused on ensuring that the benefit packages promoted are feasible, realistic, and affordable. In particular, there is demand for robust financing mechanisms to be linked through the DCP3's ten-step process. Utilization of the DCP3 requires an appropriate governance structure, such as a secretariat housed within the MOH.

5.3 REGIONAL LISTING OF INTERVENTIONS IN THE EASTERN MEDITERRANEAN

Another key resource was discussed by Dr Reza Majdzadeh, consultant for WHO EMRO: the Eastern Mediterranean region's Regional UHC Public Benefit Package (r/UHC-PBP), a set of interventions that are based on global evidence and relevant to regional characteristics. It is comprised of almost 20 categories, including NCDs and mental health, that were selected based on WHO recommendations and review of the DCP3. The r/UHC-PBP provides information on which countries should consider these interventions, along with the target beneficiary group and minimum qualifications for service providers. The r/UHC-PBP should be used as a supporting guide to countries designing and developing national UHC-PBPs (n/UHC-PBPs). The model national UHC-PBP includes two sub-packages: the Essential Health Service Package (EHSP), and the intersectional actions and fiscal policies.

5.4 PRIORITIZATION AND COSTING TOOL FOR CANCER PREVENTION AND CONTROL

Benefit packages must better align with cancer programmes. An analysis of benefit packages in three countries showed lack of coherence with national EMLs and other elements of the pathway to access care. For example, the consequence of failing to include health products in the national essential medicines leads to out of pocket payments in private pharmacies, and a lack of clinical guidelines leads to higher costs and lower service quality.

Dr Andre Ilbawi, WHO Technical Officer, NCD Department, presented a cancer costing tool developed following a 2017 WHA resolution that requested creation of a tool that prioritizes cost-effective interventions in cancer.[24] A preliminary

situational analysis revealed key challenges and bottlenecks; for example, only 9% of countries costed their cancer plans, and over 60% of LMICs that have breast cancer screening programmes are screening the wrong populations.

The tool is context-specific, evidence-based and user friendly, minimizing the data burden on the country. The tool includes a set of default values, with a database with hundreds of base inputs that can be modified using an accompanying assessment tool. Countries use the cancer costing tool to perform an analysis of current service capacity, presenting a snapshot of services and priorities. Over 100 interventions for 14 cancers can then be selected, and the user designates a preferred scale-up scenario. The tool's outputs include estimates of the health benefits, costs of health system requirements, and scale up considerations.

By the end of 2020, the cancer costing tool will be further expanded, to include 20 cancers and an estimated 200 interventions. To ensure sustainability of the tool, funding has been secured to train national and regional economic and technical experts in implementation of this tool. Applying the principles and processes across the broader NCD services is a way of progressing the alignment of inclusion of NCD in UHC BP.

WHO also provides countries with support to achieve full concordance between what is included in the benefit package and what is clinically available. In one example, a national cancer control plan with a limited budget was assessed and costed. The country received support for prioritization of cancer services, and two key efficiency gains were identified: a focus on early diagnosis, estimated to save 500 lives, with annual savings of 50,000 USD per year; and a focus on priority health products and appropriate pricing approaches, leading to 500,000 USD in savings. This work helped engage the Ministry of Health to immediately take action, resulting in advocating with Parliament for a new procurement mechanism in the country and an alteration in the treatment regimens that were used in the clinical setting.

6. FINANCING UHC BENEFIT PACKAGES

Dr Agnes Soucat discussed key points on financing UHC benefit packages. A key conceptual point in the presentation is that financing is often confused with funding. However, financing is not solely about availability of financial resources. Instead, it also includes the instruments and institutions that together lead to the best use of available resources. In addition, financial access and financial protection are all central to the health financing conversation.

HEALTH FINANCING INCLUDES THREE MAIN FUNCTIONS:

- **Revenue raising** (not disease specific), including:
  - *User payments*: These are patient specific, and represent the care that people demand and for which they are ready to pay. User payments are a massive driver of spending for NCDs.
  - *Tax revenue*: In contrast, tax revenues are society-specific and represent a vision of what the collective purse should fund. This varies across countries considering different levels of taxation, even at similar levels of country development.
- **Pooling** (not disease specific) of funding through a common set of rules, an information system, and willingness to pool money into a single pot and delegate the purchasing of health care to a third party. For example:
  - *Health insurance*: This function provides some protection intended for non-frequent and unpredictable health events. It is not well-suited for the commonly non-clinical modalities of population-based NCD prevention, particularly when entrusted to private actors.
  - *Social insurance fund*: Most countries have a more sophisticated institutional mechanism for pooling resources, such as a *social insurance fund* financed with contributions from payroll taxes or through general taxation. Most countries have replaced a pure social insurance (Bismarck model) or National Health Service (NHS) type of system with a mixed system with a large amount of public funds. Larger pools are better placed to absorb "price shocks" from higher treatment cost diseases, including some NCDs. Countries with mature UHC institutions have shown that a small share of people (typically 5%) consume the most resources (above 50%). This demonstrates the need for a strong social contract to enable cross-subsidization of one group to another (e.g. rich to poor, healthy to sick) and sufficient investment in population-based prevention interventions.
- **Strategic purchasing** (can be disease specific) is implemented by agencies in charge of pooled resources. Strategic purchasing defines how providers are paid, and how information is collected on the link between money transferred and services delivered. It operates through a benefit package, transfers, price signals and an information system. The information system allows to check whether the money that is transferred to providers is actually delivered with an acceptable level of quality (as shown in the enforcement column in Table 1 above).

By definition, UHC ensures that all people are covered with essential health services – however, the reality of limited resources necessitates rationing of *who,* and *what services*, will actually be covered. The current global realities – of longer lifespans, new technologies and improved treatment and prevention methods – are consequential for public financing. In contrast to other industries, health care is largely dependent on workforce productivity, which does not change quickly.

6.1 CHALLENGES AND SOLUTIONS FOR INTEGRATING NCDS IN UHC BENEFIT PACKAGES

Most countries can now boast of having a national multisectoral NCD plan. However, Dr Ren Minghui highlighted that the next key step is translating a national multisectoral NCD plan into prioritized service listings, through an explicit definition of benefit entitlements. Countries have made clear requests to WHO for support to fulfil global commitments to UHC; this requires embedding and expanding coverage for NCD prevention and management within the UHC entitlements included in a health benefits package.

A main challenge in incorporating NCDs in UHC benefit packages is cost. NCDs treatments are typically misrepresented as novel and expensive. In reality, high treatment costs for some NCDs arise from complications that arise due to lack of timely action to prevent, screen and treat these diseases. When administered at the appropriate time, many NCD interventions may be cost-effective and even relatively inexpensive. By helping to avert avoidable health care costs, NCD care could alleviate massive domestic spending in some countries.

There is a great need to educate and advocate with decision-makers to ensure the prioritization of NCDs in UHC benefit packages and curb avoidable costs for specialized care. In addition, there is frequently pressure to expand national service packages to include specialized treatment, such as dialysis and chronic kidney disease care in higher level facilities, while advocacy for preventive care, early screening and diagnosis is limited. This skews the distribution of funds, making it hard to discontinue certain practices and shift resources, and creating expectations to continue certain interventions that may not be the most cost-efficient or effective.

To address the challenges of a lack of available technical information and the perceived expense of NCDs, Dr Ala Alwan highlighted the need for more clarity on what should be included in a UHC benefit package. Focusing on country evidence, process, and experience is fundamental in the prioritization of services; tools like the DCP3 can guide decision-making (particularly in low-income countries), while the WHO UHC Compendium provides a comprehensive "one-stop shop" solution. Once data are available, zero-based budgeting is a key strategy to bring NCDs into the current health budget, and a health system strengthening agenda should be prioritized to deliver on core health system functions for all disease groups in line with UHC. Experiences shared by countries revealed that this is possible when there is political commitment and a country-driven process.

Regarding financing, Dr Rachel Nugent, Vice President and Director of the Global NCD Center at RTI International, highlighted that major gaps exist in NCD funding. Therefore, there is a need for substantial additional health investment in packages of NCD prevention and care – this would have the greatest impact in low-income countries. Estimates from the WHO National Health Expenditure database show that NCDs consume 38-43% of DCP3's essential universal

health coverage (EUHC) interventions by 2020, with current NCD shares varying widely.[25] The relatively stagnant donor funding is small and often directed toward costly tertiary treatment services such as cancer treatment.

The availability and allocation of domestic funding for NCDs is an issue in many countries. Potentially cost-saving prevention policies, including the NCD Best Buys, are generally underutilized; further work is required to realistically cost these policies and interventions and feature them prominently in the advocacy agenda to show what can be saved and how to effectively enforce them. NCD interventions, such as taxation of tobacco and Sugar Sweetened Beverages (SSB), are not oriented to short-term effects. Rather, they are geared to have long-term effects, which should be considered in the planning process. In addition, such "health taxes" provide revenue that in some countries has been earmarked for UHC and NCD.

Current financing options for NCDs and health include a mix of general budgetary allocations, including national health insurance programmes, donor and philanthropic support, as well as a large share of out-of-pocket (OOP) spending. The general budget share is often allocated mostly to hospitalization and medicines, with national health insurance funds supporting secondary or tertiary services. These services have limited access to broad populations, creating a financially unsustainable situation, especially given that these service packages have rarely been accurately costed. OOP payments are often misallocated in terms of efficiency and equity. Private sector financing is increasingly targeted to certain segments of populations with a social impact agenda. Finally, procurement, purchasing and payment mechanisms are fundamental components for NCD service delivery but are typically underdeveloped and poorly implemented.

To strengthen financing for NCDs, countries should consider an assessment of macro-economic and demographic conditions for fiscal potential, and development and implementation of health taxes. It is pertinent to consider costs of scaling up and scaling out, with attention to no action alternatives and estimates of possible savings from early action. Further, countries should make realistic estimates on health taxes and external funding, and move toward reducing out of pocket costs and achieving equity. Due to challenges faced by countries regarding inclusion of NCD in UHC benefit package and leveraging finance, it was agreed that there is a need to develop guidance to assist countries in ensuring NCD interventions are prioritized through a benefit package entitlement and financed within the broader context of health services.

7. COUNTRY EXPERIENCES AND LESSONS LEARNED

National and WHO experts presented on the experiences of several countries that are leading the way on working to integrate NCDs into UHC benefits and health care delivery: Ethiopia, Ukraine, Pakistan and Somalia. Experts also reflected on regional collaborations and experiences.

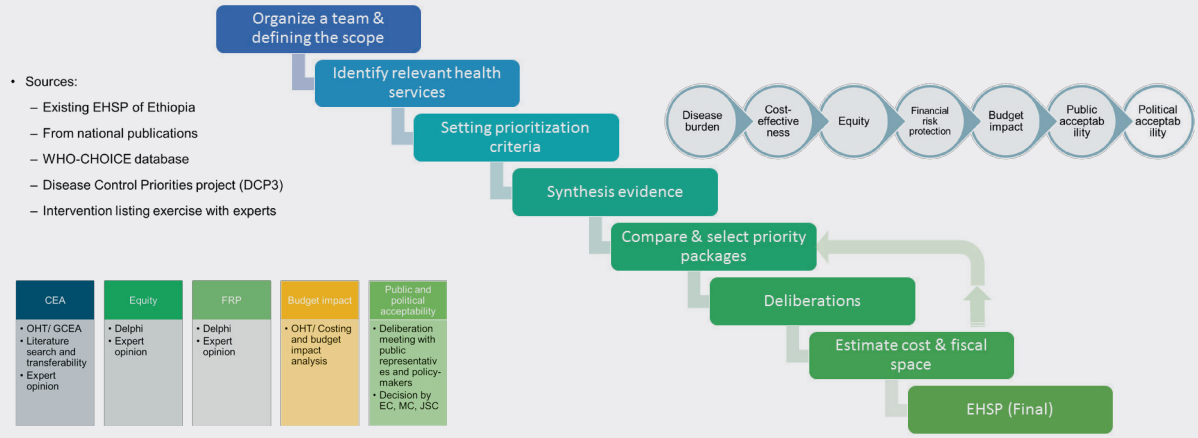
7.1 ETHIOPIA

Dr Alemayehu Hailu, Senior Health Economics Technical Adviser, Ministry of Health, Ethiopia, provided an overview of the Ethiopian EHSP and summarized the eight-step process used to define prioritized services (see Figure 2). Ethiopia's EHSP aligns with global definitions: it is a set of priority affordable, promotive, preventive, curative and rehabilitative interventions provided at all levels of health service delivery in an equitable, acceptable and sustainable manner, on the path towards UHC and within the current health care delivery system at all levels.

The development of the EHSP followed an expanded version of the 3-D framework. It included identification of more than 2000 interventions drawn from the existing EHSP, national publications, the WHO-CHOICE database, DCP3, and intervention listing exercises with experts. A two-day expert meeting was held for a comprehensive evaluation of interventions. Next, prioritization criteria were defined using literature on disease burden, cost-effectiveness, equity, financial protection, budget impact, public acceptability and political feasibility as starting points. More than 35 deliberation meetings were convened with a variety of stakeholders at different stages of the revision process. The EHSP now comprises 1018 interventions, with 33% focused on Reproductive and Maternal, Neonatal and Child Health (RMNCH), 21% on NCDs, and 18% on surgical and injury care.

The NCD interventions are aligned with WHO NCD Best Buys, with 31% of interventions focused on cancer, 15% on policy and behaviour change communications (BCC), 13% on cardiovascular disease, and others, including substance use disorders and chronic respiratory diseases. Each intervention group is further expanded into subcategories (e.g. types and stages of cancer). The NCD interventions span are characterized as either high priority (about 60%), medium priority (about 20%) or low priority (about 20%, including mostly resource-intensive interventions). The EHSP in Ethiopia focuses mostly at primary health care centres and primary-level hospitals, with nearly 50% of NCD interventions at the primary health care level and 20% at the general hospital level.

Figure 2. The process of defining the Ethiopian EHSP



Getachew Teshome Eregata et al. 2020. Revision of the Ethiopian Essential Health Service Package: An Explication of the Process and Methods Used (Under Review)

7.2 UKRAINE

Ms Natalia Riabtseva, Deputy Head of the National Health Service, Ukraine, presented the process of including NCDs and mental health in the country's national UHC benefit package. Health financing reform in Ukraine began in 2017 to improve population health outcomes and ensure financial protection, with the establishment of strategic purchasing and new provider payment mechanisms in 2018. New mechanisms were developed for all types of health care services, with priority given to emergency and hospital care.

The development of the first comprehensive health benefit package in Ukraine was initiated in 2019 with participation from a wide range of stakeholders. The National Health Service of Ukraine facilitated an active policy dialogue on development and approval of the HBP. In particular, the National Health Service of Ukraine presented and explained the HBP at a series of meetings with the Parliamentary Committee on Health, the Government, and local authorities (that own health facilities). The draft HBP was also published on the National Health Service's website, and feedback was collected from various groups, including medical professionals, patients and civil society. WHO, the World Bank and other countries provided technical support during this process, and the National Health Service of Ukraine organized complementary discussions on medical professionals and patient education. The design phase utilized the DCP3 listing of interventions. Strengthening NCD service delivery provision and distribution of financing were considered during HBP design, and international recommendations were used where national guidance was not available.

Ultimately, the government's guaranteed and funded package of health services (called the medical guarantees program) consists of 27 service packages and a wide range of out- and in-patient medications. Regarding NCDs, the guarantees specifically cover patients with CVD, bronchial asthma, and type II diabetes. Patients are entitled to receive medication at either no or very low cost. Some diagnostics and treatment are reflected in priority service packages for specialized care. Within NCDs, cancer diagnostics are fee-for-service to stimulate early diagnosis. Treatment for strokes and heart attacks are provided at certain hospitals, as are two packages for cancer treatment and psychiatric care.

Recent developments of the HBP include expanding reimbursement for a new list of medications for post-heart attack and stroke treatment, and introduction of new medicines for mental health treatment. Plans are under development to shift the system of hospital-based psychiatric care to the outpatient level while ensuring that quality of care is maintained. Additional service packages to mobilize psychiatric care are being considered as well. Throughout implementation of the HBP, the National Health Service of Ukraine remains in close dialogue with the patient and medical communities, as well as local and central authorities. Additional monitoring of budget expenditures was also undertaken, with minor adjustments made as required.

7.3 PAKISTAN

Development of benefit packages in Pakistan, Somalia and Afghanistan were shared by WHO staff members who worked with the respective governments, rather than by country nationals.

Pakistan has emerged as a model country in its region with regards to the development of the Essential Package of Health Services (EPHS). Pakistan was the first country to pilot the DCP3, following a formal request from the government in August 2018. All parties made a solid commitment to undertake joint work at all levels.

The EPHS includes prioritized interventions that were costed in five platforms, with a special focus on the district-level systems: community, health centre and first level hospital. Designing and costing the UHC EHSP, with capacity building in the Ministry of Health and external institutions such as Aga Khan University, drove major progress and provided valuable learning experiences. The entire prioritization process was country-owned and executed, with strong government commitment to a systematic, open and transparent process at each phase, including gathering data, engaging in dialogue and decision-making.

Interventions were prioritized into high-, medium- or low-priority interventions, and costed accordingly. Two alternative packages were then developed that accounted for Pakistan's disease burden, circumstances, health system capacity, and fiscal space:

Package 1

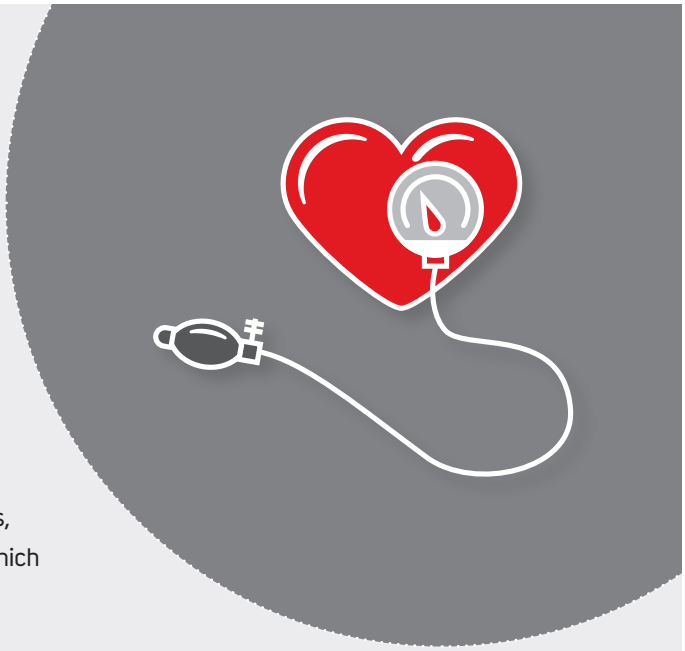
- All high-priority level interventions included (107)
- Estimated annual per capita cost of service package: 25.4 USD
- Costed interventions and the coverage level for intermediate implementation, with a different cost per year over a ten-year period, linked to a target of moving toward UHC with a targeted 80% coverage by 2030.

Package 2

- High- and medium-priority interventions included (128)
- Estimated annual per capita cost of service package: 28.2 USD

The packages were reviewed by a National Advisory Committee (NAC), with recommendations sent to the international advisory group, and further analytical work planned to finalize the EPHS submission to the steering committee. The NAC recommendations included endorsing the first package as the national EPHS, with a phased approach to covering all interventions in the package, and endorsing the expanded implementation scenario pending further assessment of the fiscal space.

7.4 SOMALIA AND AFGHANISTAN



Somalia and Afghanistan are both considered emergency states, adding to the contextual aspects that need to be taken into consideration. Although both countries are advanced in terms of defining benefit packages, their exercises have been donor-driven. This has ultimately affected the selection of services. In these cases, the costs of services are assessed in order to determine which services could be funded by donor-committed resources.

However, the essence of benefit package design is that it should stem from country needs and not be solely directed by donors. Key lessons related to messaging and communication on NCDs emerged from Somalia's experience. Based on the misconception that NCDs are novel and require expensive interventions, anxiety was revealed about whether the health system would be able to support effective NCD services. In reality, NCD services such as blood glucose testing by glucometer or blood pressure measurement are similar to the administration of oral therapy and other services that health care workers already perform. For example, nurses check pregnant women for signs of gestational diabetes, relying on the same methods needed for standard NCD treatment.

The country experiences highlighted a few key learnings for successful development of UHC Benefit Packages that include NCDs:

- Initiation and progress of UHC BP design require strong political commitment to UHC.
- Long-term investments are needed to build local capacity in the health and economic sectors and academia on the principles of prioritization.
- Benefit package design should stem from country needs and not be solely directed by donors.
- Transparent, systematic and country-owned processes for adapting and prioritizing intervention listings are recommended.
- Effective messaging and communication are needed to simplify the language used and in particular to address misconceptions that NCDs are novel and require expensive interventions.
- The use of the WHO 3D Framework for prioritization of services in a country-driven process usually results in NCD interventions being prioritized when there is political commitment.
- Benefit package design is just a starting point. Countries must work in parallel to develop and implement technical guidelines on various aspects, including workforce capacity, which are essential to the effective delivery of NCD services.

8. REGIONAL INITIATIVES

8.1 EASTERN MEDITERRANEAN REGIONAL GUIDANCE

Experience in the Eastern Mediterranean Region (EMR) highlights that ministerial engagement is a driving force for UHC benefit package development executed through a transparent, country-owned process with active engagement by policy-makers and national stakeholders. EMR countries' experiences demonstrate the need to focus on feasibility and affordability, which is realized through preparatory work to survey which services are currently available and accessible.

The development of a regional package and guidance by the WHO EMR Office (EMRO) is intended to support countries to adapt a targeted set of interventions into a national priority benefit package. The regional package includes fiscal and intersectoral actions and policies to respond to the complex needs of people living with NCDs (PLWNCDs), seeking to avoid a fictitious dichotomy between individual- and population-based interventions.

Dr Reza Majdzadeh provided an overview of the forthcoming EMRO guide. This guidance document, like the WHO UHC Compendium, uses a traffic light system to compare a country's existing interventions against a reference list in order to improve efficiency by reallocating services as appropriate. Following the 3-D prioritization framework, the recommended dialogue process highlights the necessity of community engagement. The method of prioritization and accountability is a Multiple Criteria Decision Analysis framework with concrete decision rules. Detailed processes for determining accountability and reasonableness and for an analysis of the health system capacity to assess readiness and necessary changes for implementation are included. Recommendations are presented on the use of legislation and regulatory processes, and methods of institutionalizing capacity building, financial and human resources and infrastructure.

Among the 22 countries in the EMR, 12 have asked for support with the development of national benefit packages and have demonstrated strong wills to progress the work by committing to several years of political engagement in benefit package development. Several documents and events signal regional and country commitments to the work, including the WHO EMRO "Framework for action on advancing UHC in the Eastern Mediterranean Region" (2014), a consultative meeting held in 2017, the 2018 Salalah Declaration on UHC, and the Regional Director EMR's Vision 2023.

8.2 EUROPEAN REGIONAL ASSESSMENT

The WHO European Regional Office (EURO) has adopted a health systems perspective to improve health outcomes for NCDs. It sought to assess countries' policies, benefit packages, services, health provider capacity and patient demands in order to determine which services were required and to understand health system challenges for NCD care. Drawing on a framework developed for a EURO-led assessment of Sexual and Reproductive Health (SRH), the assessments revealed that health benefit packages are often nominally "all-inclusive"; however, limited funding leads to implicit rationing and OOP payments, and these exacerbate inequalities.

The process of designing benefit packages is generally poorly defined and lacking in transparency. This results in no clear inclusion and exclusion criteria for services, no apparent focus on equity, lack of costing of services, and limited monitoring and evaluation systems in place. Further, although PHC is a critical part of NCD management, the whole continuum of acute care and specialized care including follow-up and rehabilitation must be considered. Another lesson learned from the prioritization process for SRH services was that a human rights-based analysis is particularly important to consider, as the benefits selected can be shaped by politics and cultural bias with significant negative effects on the most vulnerable.

9. COUNTRY IMPLEMENTATION

The road to including NCDs in UHC benefit package design and implementation at country level begins with strategic advocacy to drive the HBP agenda forward; this can be aided through the use of investment cases. A policy goal for NCDs should reflect a country's values, results of the 3-D (data, dialogue and decision) process, and definition of the budget share available for NCDs.

Once an NCD policy goal has been defined, several steps are required to ensure that NCDs are incorporated into the country's UHC Benefit Package and financed. These include:

- Aligning or streamlining the **NCD strategy** with the National Health Sector Plan
- Conducting **strategic advocacy**, aided by robust collection and analysis of data and use of investment cases and other tools, for inclusion of NCDs within the Prioritized Health Benefit Package
- Engaging all relevant stakeholders in the **UHC Benefit Package design process** to promote inclusion of NCDs , including:
  - Establishing a **priority list of NCD interventions** using existing resources such as the Best Buys, local evidence and analysis, and tools such as the UHC Compendium and DCP3
  - Estimating **costs**, which involves considering system costs, nonlinear scaling of services, delivery modalities and changing markets
  - Engaging health planners, communities, and citizens in the prioritization process
- Leveraging **financing** for NCD services, including:
  - Advocating for and developing a measure of **fiscal effort** and projections; this may involve assessing macro-economic and demographic conditions for fiscal potential and developing and implementing **health taxes**, such as tobacco, alcohol and SSB taxes
  - **Securing funds** for health through reprioritization of government funding; this may require initiating an in-depth fiscal space analysis, avoiding generic arguments to non-health sector actors, linking to the investment plan, gathering concrete evidence of efficiency and economic gains and engaging in high-level advocacy
- Enforcing implementation, including:
  - Strategic communications to enforce access to health benefit entitlements through accountability measures
  - Creating a robust monitoring and evaluation mechanism to ensure equity and transparency

WHO and other technical partners are well-suited – and keen – to support Ministries of Health in tackling their fundamental roles in policy coordination, regulation, budget negotiation and coordination of fiscal instruments.

10. CONCLUSIONS

The following conclusions emerged from the consultative meeting:

1. Resources are always limited and needs are numerous. Rationing is therefore required to achieve UHC; **explicit rationing** is key to promoting equity, fairness and effectiveness in health coverage.

2. Governments should **accelerate national efforts** on UHC Benefit Package design and implementation. Valuable country cases exist which can be used as a basis.

3. **Political leadership**, including will and engagement, by Ministries of Health is a key driver in the development of essential health service or benefit packages. More remains to be discovered about how best to motivate the process, including through advocacy and steering political commitment.

4. The **8 Principles of Design for UHC Benefit Package** are important for countries to consider when developing a UHC Benefit Package.

5. More investment is needed in institutionalizing the data space at country level to ensure that the design of UHC Benefit Packages is a **data-driven and evidence-based process**.

6. **Several useful tools**, including the UHC Compendium, DCP3 and EMR UHC-PBP guide, exist to support priority-setting and benefit package development. They provide good starting points for countries as they contextualize recommendations and provide concrete criteria for national benefit package design.

7. Benefit package design should be linked to robust and sustainable **domestic financing mechanisms** to ensure adequate resources availability for health and NCD services.

8. **Development assistance** can provide a catalytic source of funding for NCD services in the short term.

9. A whole-of-government approach is best placed to advance improvements in NCD service coverage, which require **inter- and multidisciplinary actions** across health, finance, education, agriculture, transport and other sectors. Consideration of a health economics and health system perspective is useful at several levels.

10. Governments are encouraged to **invest in core functions** that respond to market failures to ensure delivery of public goods. This approach will enable NCDs to become a priority when considering policies on taxation and regulation (of food, industries, alcohol, etc.).

11. **High-level advocacy and education** are needed to counter misconceptions that NCD services are expensive, novel, or unsustainable. Using language that refers to a country's **core value system** can further support feasibility and cost-effectiveness arguments.

12. **Integrating services** for communicable and noncommunicable diseases is critical, as it reflects country realities. The COVID-19 pandemic has highlighted and amplified the need for health systems strengthening to deliver all core services.

13. Governments can **expand domestic resources** for NCD services by: using existing funds more efficiently; reallocating existing funds; raising new revenue through taxing tobacco products and SSBs, and other health related taxation; and, improving tax compliance.

14. **International financing** can be leveraged to catalyse NCD service delivery. This includes development bonds and loans, private investment and other innovative funding streams.

15. Governments should systematize efforts in defining the role of the private sector in financing and resource redistribution to address NCDs in collaboration with WHO and other technical partners.

16. The **3-D framework for prioritization and decision-making** helps countries with benefit package design and financing by promoting the use of:
    a. **Data** to assess the burden of disease, cost-effectiveness, budget impact, financial risk protection, fairness and acceptability;
    b. **Dialogue** to prioritize health services, which promotes legitimacy, accountability, transparency and inclusiveness in the design process; and,
    c. **Decision** to include citizens' voices in the political process promoting equity.

17. The entire process of integrating NCDs in Health Benefit packages must be **country owned and executed**, with strong government commitment, an open and transparent process, and a systematic approach to each step of gathering data, engaging in dialogue and decision-making.

18. WHO is ready and willing to provide **global and/or regional guidance** on the design, implementation and enforcement of UHC Benefit Packages and ensuring the inclusion of prioritized NCD services.

ANNEX 1. ROADMAP FOR COUNTRY IMPLEMENTATION

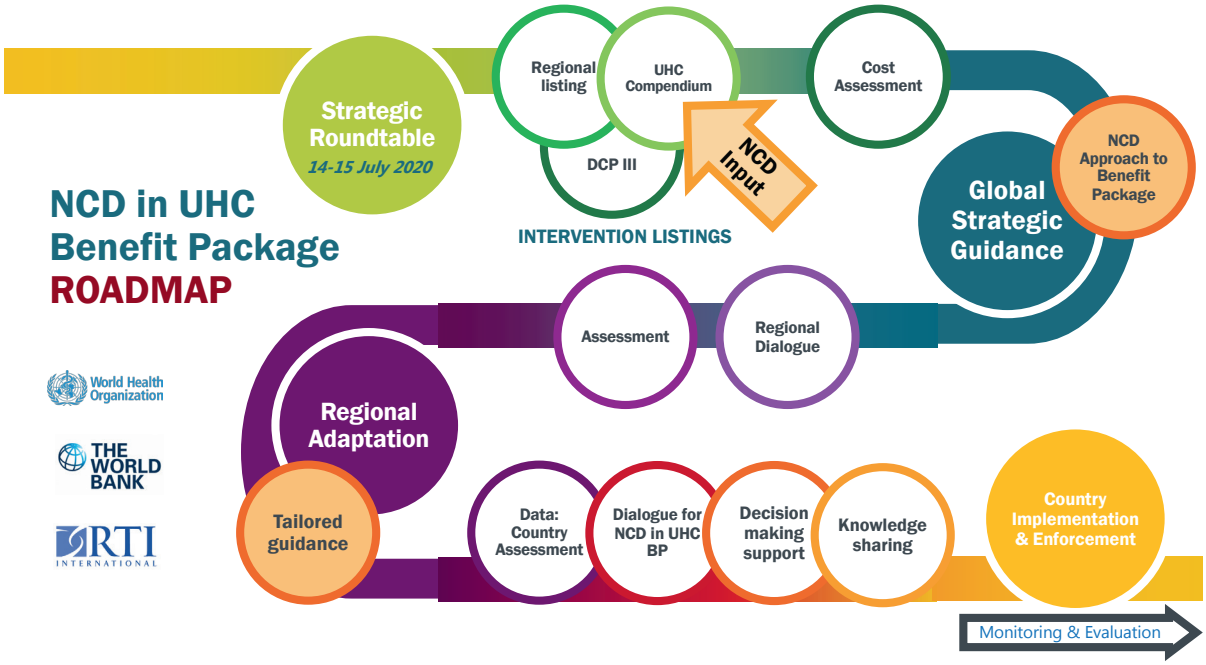
WHO HQ, Regional Offices, and global partners recognize the need to provide strategic guidance to aid Member States in the design of UHC benefit packages, with a particular emphasis on the inclusion and guarantee of NCD services.

The Key Questions for consideration on support by WHO and partners to countries are:

- What should be included in a UHC benefit package (based on country context and demand)?
- Which countries are included? Should the focus be on LMICs or could it expand to upper middle-income countries which have expressed interest?
- What goes in each package? How can the packages account for evidence, process, and experience of countries?
- How do the materials address health system strengthening components?

Further development of such guidance will be led by the Department of Health Governance and Finance (HGF), with specific data inputs (including costs, health impacts and health system requirements for NCD services) provided by the Department of Noncommunicable Disease (NCD). WHO will work at the global, regional and country levels to support national activities, with backing from external partners, for a unified approach to UHC benefit package design, roll-out and enforcement. Figure 3 shows an overview of the Roadmap; each step is detailed further below.

Figure 3. Roadmap for implementation of inclusion of NCDs in UHC Benefit Package Design



Next phases of the Roadmap:

I. Develop **Global Strategic Guidance on UHC Benefit Package Design** through:

- Update and finalization of the global intervention compendium and data repository
  a. Input and finalize listing and definitions of NCD interventions in the UHC compendium
- Develop country-level modelling tools
  a. Assess costs, health impacts, and health system constraints associated with delivering specific service packages.
  b. Contribute inputs on NCD-specific areas of service delivery.
- Prepare guidance on design and development of essential health service and benefit packages
  a. Create guidance, including health workforce requirements, in support of selected health services.
  b. Facilitate strategic global dialogue on the alignment/positioning of UHC benefit package and service listings.
  c. Generate new evidence and data through case studies of existing benefit packages.
  d. Develop tools/guidance on how to ensure prioritization of NCD interventions in benefit package development.

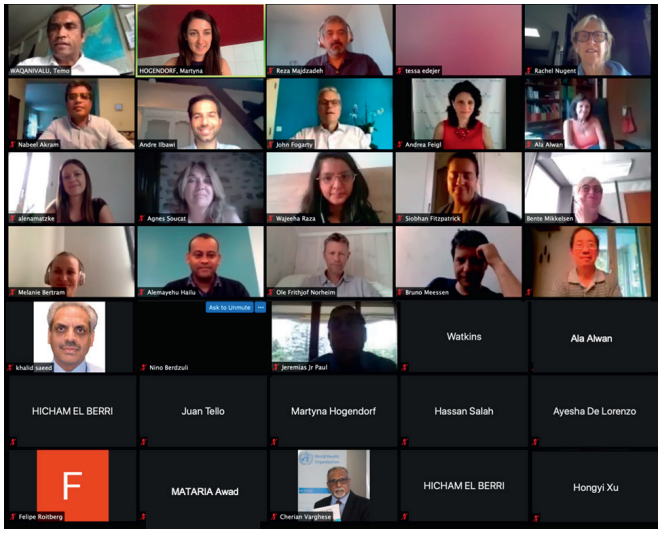
II. Facilitate **Regional Adaptation** of Guidance, including:

- **Assessment and consensus building:** Conduct regional strategic consultations to develop action plans to assess the countries' current status and need for support on UHC benefit package design.
- **Tailored guidance and tools:** Further define context-specific guidance on UHC benefit package design across settings, including conflict and emergency settings; provide support for institutionalizing NCD data collection systems that feed into existing data, dialogue and decision-making processes.
- **Regional intervention listing:** Develop a complete list of region-specific options and guidance for Member States on how to develop contextualized and tailored priority service listings.

III. Provide **support to countries**, including:

- Data
  a. "Health System Response to NCD" profiles for countries to provide concise situation analysis of NCD representation/inclusion across all health system building blocks.
  b. Data collection and analysis of cost-effectiveness and budgetary impacts.
  c. Capacity building for local workforce on data collection and methods.
  d. Establish a network of regional and country experts to support data analysis for NCD interventions in health benefit package discussions.
- Dialogue
  a. Convene national dialogue and technical working groups on interventions included in national health benefit packages.
  b. Technical assistance to conduct data analysis and support translation of data into format required for deliberative dialogue processes for health benefit package design and implementation.
- Decision-making
  a. Technical support to countries in decision-making.
  b. Strengthening service coverage and delivery as defined in national health benefit packages.
- Communication and knowledge-sharing
  a. Develop and maintain knowledge platforms and/or communities of practice for knowledge and experience sharing within and between Regions.

ANNEX 2. LIST OF PARTICIPANTS



EXTERNAL PARTICIPANTS

Dr Ala Alwan
Regional Director Emeritus
WHO Eastern-Mediterranean Region

Dr Alemayehu Hailu
Senior Health Economics Technical Advisor
Ministry of Health, Ethiopia

Professor Ole Frithjof Norheim
Department of Global Public Health and Primary care
University of Bergen

Dr Natalia Riabtseva
Deputy Head
National Health Service of Ukraine

Dr Miriam Schneidman
Lead Health Specialist
World Bank Africa Region

Dr Rachel Nugent
Vice President
RTI International

Dr David Watkins
Assistant Professor Medicine, Global Health
University of Washington

Dr Nabeel Akram
Director of Global Operations
Health Finance Institute

Dr Andrea Feigl
Founder and Executive Director
Health Finance Institute

WORLD HEALTH ORGANIZATION PARTICIPANTS

REGIONAL OFFICE FOR AFRICA

Dr Jean-Marie Dangou
Coordinator
Noncommunicable Diseases

REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

Dr Khalid Saeed
Acting Interim Director
Mental Health and Neurological Disorders

Dr Awad Mataria
Director
Universal Health Coverage/Health Systems

Dr Reza Majdzadeh
Consultant
Universal Health Coverage/Health Systems

Dr Hicham el Berri
Medical Officer
Noncommunicable Disease Management

Dr Hassan Salah
Regional Adviser
UHS-Primary Health Care

REGIONAL OFFICE FOR EUROPE

Dr Nino Berdzuli
Director
Division of Country Health Programmes

Dr Natasha Muscat Azzopardi
Director
Division of Country Health Policies and Systems

Ms Anastasiya Brylova
National Professional Officer
Ukraine

Dr Juan Tello
Senior Policy Adviser
Integrated Prevention and Control of NCDs

Mr Gabriele Pastorino
Technical Officer
Health System Governance

Ms Triin Habicht
Senior Health Economist
Health Financing

Dr Ayesha De Lorenzo
Technical Officer
Health Services Delivery

HEADQUARTERS (HQ)

Dr Ren Minghui
Assistant Director-General
UHC/Communicable & Noncommunicable Diseases

Dr Bente Mikkelsen
Director
Department of Noncommunicable Diseases

Dr Agnes Soucat
Director
Health Systems Governance and Financing

Dr Svetlana Akselrod
Head of Secretariat
Global NCD Platform

Dr Nick Banatvala
Manager
Global NCD Platform

Mr Jeremias Paul Jr
Coordinator
Tax Fiscal Policies for Health

Dr Tessa Edejer
Coordinator
Economic Evaluation and Analysis

Dr Melanie Bertram
Technical Officer
Economic Evaluation and Analysis

Mr Bruno Meessen
Senior Health Financing Advisor
Health Financing

Dr Teri Reynolds
Unit head
Clinical Services and Systems
Integrated Health Services

Mr Menno Van Hilten
Senior External Relations Officer
Office of the Director
Department of Noncommunicable Diseases

Dr Cherian Varghese
Coordinator
Management-Screening, Diagnosis and Treatment
Department of Noncommunicable Diseases

Dr Ruitai Shao
Programme Management Adviser
Office of the Director
Department of Noncommunicable Diseases

Dr Andre Ilbawi
Technical Officer
Management-Screening, Diagnosis and Treatment
Department of Noncommunicable Diseases

Dr Hongyi Xu
Technical Officer
Integrated Service Delivery
Department of Noncommunicable Diseases

Ms Martyna Hogendorf
Consultant
Integrated Service Delivery
Department of Noncommunicable Diseases

Dr Temo Waqanivalu
Unit Head
Integrated Service Delivery
Department of Noncommunicable Diseases

ANNEX 3. MEETING PROGRAMME

Tuesday, 14 July 2020		
13:30 – 14:00	**Network and introductions**	
14:00– 14:15	Opening Welcome Remarks Objectives of the meeting	**Dr Ren Minghui** Assistant Director-General, UCN **Dr Temo Waqanivalu**
14:15 – 14:40	**NCD and Health System overview** **Essential packages of Health services as an integral part of Financing for UHC**	**Dr Bente Mikkelsen** **Dr Agnes Soucat**
14:40 – 15:10	**Plenary Discussion:** UHC Benefit Package	**Dr Temo Waqanivalu** **Dr Tessa Edejer**
15:10	Health Break	
15:15 – 16:00	**Country Examples:** Essential interventions for NCDs and mental health in National UHC Benefit Package Pakistan Ethiopia Ukraine	 **Dr Malik Safi** **Dr Alemayehu D Hailu** **Dr Natalia Riabtseva Volodymyrivna**
16:00 – 17:00	**Plenary Discussion:** Closing the Gap	**Dr Ala Alwan** **Dr Bente Mikkelsen**

Wednesday, 15 July 2020		
13:30 – 14:30	**Priority setting initiatives & UHC Benefit packages** DCP 3 & Country translation work UHC Compendium & Benefit Package EURO Assessment Guide EMRO UHC BP Guide	 **Dr Ala Alwan** **Dr Melanie Bertram/ Dr Andre Ilbawi/ Dr John Fogarty** **Dr Nino Berdzuli** **Dr Awad Mataria**
14:30	Health break	
14:35 – 15:00	**Financing UHC Benefit Package**	**Dr Rachel Nugent** **Dr Agnes Soucat**
15:00 – 15:30	**Plenary Discussion:** NCD in UHC Benefit Package	**Dr Temo Waqanivalu** **Dr Awad Mataria**
15:30 – 16:00	**Roadmap for Global Guidance and Country Support**	**Dr Temo Waqanivalu** **Dr Tessa Edejer**
16:00 – 17:00	**Plenary Discussion:** Next Steps	**Dr Bente Mikkelsen** **Dr Agnes Soucat**
	Closing	

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