BENEFIT DESIGN: THE PERSPECTIVE FROM HEALTH FINANCING POLICY
ABOUT HEALTH FINANCING POLICY BRIEFS

WHO Health Financing Policy Briefs are short papers which summarize current evidence and thinking on a topic of strategic importance for universal health coverage. They are based on a detailed review of the literature, and discussion and debate about the guidance and recommendations for Member States based on this evidence. Health Financing Policy Briefs target policy makers and technical advisors working in health financing or in health systems strengthening more broadly.

ACKNOWLEDGEMENTS

Main contributors to this paper are Matthew Jowett (WHO Geneva), Joseph Kutzin (WHO Geneva), Triin Habicht and Sarah Thomson (WHO Regional Office for Europe), and Melanie Bertram (WHO Geneva).

The text was reviewed by Karin Stenberg and Andrew Mirelman (WHO Geneva). Additional feedback was provided by participants in an internal seminar of the Department of Health Systems Governance & Financing.
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Benefit design considers how all public revenues for individual health services are used, not only those in schemes with explicitly defined entitlements, or those serving a limited population. Benefit design is also concerned with policies regarding the use of private revenues for publicly mandated benefits.

Where multiple coverage schemes or programmes operate side-by-side, each with its defined target population, benefits, and health financing policies, it is critical to minimize duplication and inefficiency, ensure transparency for service users and providers, and ensure coherence across the health system to leverage positive change.

Conditions of access to publicly funded health services include decisions related to price e.g. whether patients make co-payments, and non-price e.g. which treatments are subsidized, in which facilities, and whether a referral system must be followed. Conditions of access should support service delivery objectives.

Reducing uncertainty for both service users and providers is a central objective of benefit design; uncertainty around entitlements and conditions of access constitutes a significant barrier to access and can increase inefficiency in the health system. Entitlements should be explicit but not overly detailed, particularly for first-contact care. Co-payments, if applied, should be fixed in absolute terms, and kept low, both to reduce uncertainty and to protect users against financial hardship.

Aligning benefit design with health financing policies is essential to implement policies effectively. Of particular importance are budget mechanisms which explicitly allocate funds to priority health services, and the establishment of provider incentives which support service delivery objectives, limit cost escalation, and promote efficiency and quality.

**Key Messages**

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- Aligning benefit design with health financing policies is essential to implement policies effectively. Of particular importance are budget mechanisms which explicitly allocate funds to priority health services, and the establishment of provider incentives which support service delivery objectives, limit cost escalation, and promote efficiency and quality.
1 BENEFIT DESIGN AND HEALTH FINANCING FOR UHC

1.1 SCOPE AND POLICY RELEVANCE

a) Health financing comprises the functions of revenue raising, pooling, and purchasing, as well as policies on benefits i.e. the entitlements and obligations of the population. Benefits are the service and population entitlements fully or partially funded from public revenues, or which are publicly mandated. Policies define who is covered, for which services and related products e.g. medicines, and with what if any charges at the point of service.

b) The basis for entitlement to publicly funded services and products may be either contributory or non-contributory. In most countries being a citizen or resident, or part of a population group e.g. low income, gives the right to certain entitlements. This is referred to as non-contributory or automatic entitlement. In contrast, where entitlements are conditional on a specific financial contribution, most commonly under health insurance schemes, the basis for entitlement is contributory [1]. In many health systems contributory and non-contributory entitlements co-exist. Extensive reliance on contributory-based entitlement can limit progress towards UHC especially where informal employment is significant [2] and employment status fluid [3].

c) Benefit design should account for the use of all public funding for individual health services¹, and is of central importance for UHC, and health outcomes [5]. Public revenues are compulsory, pre-paid, and pooled [6]. The flip side of benefits are services that must be paid for from private sources, either fully or partially. Benefit design policy hence involves rationing access [7]; non-covered (excluded) services are left to the market, whereas partially covered services require private funding such as co-payments (user fees²) for publicly mandated benefits. These policies have implications for both equity in service use and financial protection.

d) Benefits may be defined explicitly or implicitly but they exist in all health systems. Increasingly, governments are explicitly defining what they will and will not fund i.e. how services and related products are rationed or prioritized. Defining a list of priority or essential services free at the point of service is one such approach [8]. When benefit entitlements are not explicit, accountability and transparency is often compromised, limiting policy maker’s

¹ Common Goods for Health (CGH) refer to population-based services and functions [4] and are also part of a broader process of prioritization. In this document we focus on individual services and assume that funding for CGH has already been decided.

² Co-payments and user fees have the same meaning in health financing, and we use the terms interchangeably.
leverage over the health system, and disempowering the population; implicit rationing occurs as a result.

e) Benefit design policy can drive progress to UHC when policies on entitlements and conditions of access are aligned with each other and with service delivery objectives. Specifically, a focus on the services and products, population groups, and conditions of access that maximize equity in access to quality health-care services, including essential medicines and vaccines, and which also protect service users from financial hardship due to out-of-pocket payments [9, 10], will drive progress to UHC.

1.2 BENEFIT DESIGN DECISIONS: SERVICES AND CONDITIONS OF ACCESS

a) No country can publicly fund all health services and products and hence must prioritize and manage trade-offs to maximise progress towards UHC. A dedicated process should be established to allow societal values and preferences to be expressed, and to navigate competing objectives [11] e.g. reaching fewer people to ensure access for remote communities when the cost per patient is relatively high. This process\(^3\) should involve relevant government ministries, health purchasing agencies, service providers, industry bodies and citizens’ groups. Purchasing agencies in particular play a pivotal role in operationalizing both defined benefits, and conditions of access [12].

b) Benefit design also involves decisions about conditions of access to publicly funded or mandated services. Conditions of access define which specific treatment or medication the service user is entitled to, in which type of facility, whether a referral system must be followed, and whether a co-payment must be made. All health systems, whether in high, middle or low-income countries, apply conditions of access to health services [7].

c) Price mechanisms, most commonly co-payments, are widely used as a condition of access to publicly funded benefits. Where official co-payments or user charges are implemented, the services or products concerned are only partially publicly funded. Excluding services or products completely from public funding also constitutes price rationing given that full payment must be made to access these services. Price rationing occurs implicitly when, for example unofficial or under-the-table payments are made to obtain services [13].

d) Non-price mechanisms are also widely used as conditions of access. Examples include conditions based on time (e.g. service users must join a waiting list), volume (e.g. service users face limited free consultations), health facility type (e.g. only public facilities or those in a preferred-provider network), health system level (e.g. use of a referral system), or the type of treatment or intervention (e.g. only cost-effective treatments [14], or generic medicines, are publicly funded).

e) The process of defining which services and goods to publicly fund, and which conditions of access to use,
should result from a consideration of technical and political issues [11, 15]. The use of evidence is critical to make informed decisions and should be organized around explicit criteria⁴ [16]. Financial and economic considerations include the quality of evidence on cost-effectiveness of available treatments and diagnostics, the extent to which services drive financial hardship, and estimates of the fiscal impact in the short, medium, and long term. Once entitlements are agreed, the necessary legal and regulatory mechanisms need to be established, together with mechanisms to update benefit decisions as new evidence becomes available.

⁴ Commonly used criteria recommended for consideration are the balance of health benefits and harms, human rights and sociocultural acceptability, health equity, equality and non-discrimination, societal implications, financial and economic considerations, and feasibility and health system considerations, and quality of evidence.
2 WHAT WE KNOW FROM THEORY AND PRACTICE

2.1 UNCERTAINTY REGARDING ENTITLEMENTS

a) Uncertainty plays out in a number of ways in health systems and in most cases constitutes a barrier to accessing needed services [17]. Uncertainty amongst service users about entitlements is common, both in terms of knowing which services are free at the point of service, or the co-payment required. Furthermore, the patient may face a situation different from official policy when at the facility [18]. Uncertainty may also arise when entitlements are defined in excessive detail, the effect being to delay the decision to seek care, and in some cases to not seek care at all.

b) Many countries are establishing explicit service guarantees for the population. This approach can increase certainty for service users regarding their entitlements, implemented for example through essential or priority health benefit packages. In Chile, the AUGE plan guaranteed a set of entitlements irrespective of their insurance scheme affiliation [19]; Malawi first introduced an essential health package in 2002 [20], and countries such as Bangladesh, Botswana and Ethiopia are following a similar approach.

c) Increasing transparency does not necessarily require defining entitlements in detail. As noted earlier, from the population perspective greater detail can increase confusion, especially with exhaustive positive lists. In the early years of AUGE only 43 percent of beneficiaries under treatment for cervical cancer were aware that the condition was included [19]. Avoiding complex entitlements is particularly important at the first point of care, when patients present with symptoms rather than diagnoses.

d) Uncertainty also arises when multiple benefit packages co-exist with overlapping or uncoordinated policies. In such situations, ensuring coherence across schemes, for example through harmonization of benefit policy, or the establishment of a universal guarantee across schemes, is critical to mitigate the negative consequences of fragmentation for both service providers and users.

2.2 UNCERTAINTY REGARDING CO-PAYMENTS

a) User charges (user fees, co-payments) are one of the most common conditions of access and frequently generate uncertainty for service users. When user charges are defined as a percentage of the final bill (sometimes called coinsurance) which is often uncertain ex-ante, service users have little idea how much they will have to pay, impeding an informed
decision on the affordability of care-seeking.

b) *Even low co-payments are an obstacle to service use particularly for low-income groups* [21]. Evidence shows that co-payments reduce use of both necessary and unnecessary services and medicines [22]. Mere declarations of free care without corresponding measures to ensure effective coverage also undermine progress towards UHC. Given that in most low- and middle-income countries service users will have to make direct payments for certain health services, co-payment policy needs to be explicit, and designed in a way that reduces barriers to seeking care and incorporates protections against financial hardship.

c) *Fixed co-payments of an absolute amount are easier for people to understand than percentage co-payments by reducing uncertainty about direct cost obligations.* Alternative policy measures include exemptions and annual caps on individual co-payment liability, although these may be difficult to implement where administrative capacity is weak and routine information on income is unavailable [23]. Exemptions that focus on things that can be easily defined e.g., certain types of health facilities or geographical areas, are more likely to be feasible. By ensuring that fixed absolute co-payments are low for priority services, financial hardship can be minimised for those services.

d) *The cost of medicines is often uncertain and is the primary driver of poor financial protection in many countries.* Evidence from south-east Asia highlights medicines as the dominant component of out-of-pocket expenditure on health care, [24] a trend which seen globally including in the European Region [25, 26]. In part this trend is driven by growth in non-communicable diseases and need for long-term medication, which are often not included in publicly funded benefits.

e) *Transparency in entitlements and conditions of access removes uncertainty for service users and are a key policy objective.* Publicly funded services and products represent a promise, or social contract, between the government and the population. Many countries use positive lists to explicitly define entitlements; negative lists define excluded services. A prerequisite for effective implementation is that people clearly understand the services and products they are entitled to, as well as any conditions of access, particularly whether a co-payment must be made. Avoiding excessively detailed entitlements and overly technical language is fundamental to ensure clarity and transparency, particularly for first-contact care.

### 2.3 Benefit Design, Progressive Universalism and UHC

a) *The basis for entitlement to health benefits can have a significant impact on progress towards UHC.* In economies where formal employment dominates and where social safety nets are established, a contributory-based approach may support progress towards UHC so long as mechanisms, including general budget transfers, are in place to include the poor, unemployed, and self-employed. However, where informal or non-salaried
employment is high, a contributory approach in which earmarked taxes on salaried workers (social insurance contributions) drive entitlements may undermine progress, working against equity and efficiency [2]. In addition, when people transition between formal and informal work, and lose or change jobs, the interruption in entitlements can be harmful for continuity and quality of care [27].

b) When the benefit landscape is highly fragmented, for example where multiple schemes target different population groups, there is a risk of designing inequity into the health system. Many countries have established health insurance schemes for salaried workers, with a dedicated benefit package more generous than those provided to non-salaried workers. This approach increases public funding for those who are already better-off [28-30], structurally embedding inequity into the health system. Even where a single purchasing agency exists, there may be multiple schemes within, resulting in the same problematic consequences of fragmentation.

c) When an insurance scheme covering a better-off population group e.g. salaried workers, provides an enhanced level of publicly funded benefits, several UHC-oriented policies can be considered. For example, expanding coverage beyond this narrow group can take place through budget transfers for non-salaried workers [31], or by breaking the link between entitlement and financial contribution as in France [32]. Other measures include establishing common benefits based on citizenship or residence which run alongside such a scheme, as in the case of the AUGE programme in Chile [33], or the progressive harmonization of benefit entitlements across schemes targeting different population groups, as in Thailand [34].

d) Progressive universalism (and realisation) prioritizes full population coverage with a narrower scope of services rather than the opposite [28]. Moving policy in this direction implies reducing the scope of publicly funded benefits but expanding beyond a narrower targeted population, coupled with an explicit policy on user charges for services not fully publicly financed. Political feasibility will constrain choices but strategically, efforts to build greater universality into the system rather than expanding coverage for those easiest to capture, typically better-off groups such as salaried employees [28] would be both fairer, and consistent with UHC [29].

2.4 ALIGNING BENEFIT DESIGN AND HEALTH FINANCING POLICY

a) When declared benefits are not aligned with available financial or human resources, either unmet needs or unofficial payments will increase as a result [35]. The better-off are more likely to find alternative ways to access services, exacerbating existing inequities. Even when adequate, funds will not flow to priority services without explicit budget and payment mechanisms. The lack of a link between available funds and priority services can lead to misalignment at the system level between stated policy priorities, and how funds are spent.
Input-based approaches to budgeting and purchasing tend to be least effective at establishing this connection, with many countries now using alternatives, such as programme-based budgeting, to improve alignment [12, 36].

b) Even when a set of universal benefits are established, inequities in effective coverage will remain. A systematic review of the implementation of essential health packages found significant barriers in access due to factors including inadequate supply-side readiness, especially regarding human resources for health [37]. Malawi is one example, having faced problems implementing its EHP due to shortages of staff and medicines [38].

c) Indirect costs are often a significant barrier to seeking health care including spending on transport, food and accommodation, medicines, and other supplies. Time costs can also lead to significant lost income [39] and tend to fall unevenly across the population, often being highest for poorer households [40]. Overall, the effect can be delays to the decision to seek care, to reach a health facility, or to receive care once at the health facility [41]. Benefit design should consider these costs as part of understanding which services drive financial hardship, and potentially include strategies to overcome them [42].
3 SUMMARY AND WHO’S PERSPECTIVE

a) Benefit design policy should be comprehensive, explicit, and consider all public funds available for the health system. Once funding is allocated to population-based services and functions, benefit design should focus on driving progress to UHC through the strategic use of public funds through the government budget, as well as purchasing agencies responsible for mandatory health insurance schemes. Benefit design also includes steering private health expenditures in support of UHC, for example through publicly mandated benefits.

b) Countries should develop and institutionalize a systematic process to govern decisions on benefit entitlements. The process should define a range of criteria to guide decisions, using available data and evidence, and be agreed by a range of stakeholders, not only health financing agencies. Both decisions and related administrative mechanisms should be institutionalized through the necessary legal and regulatory decisions both to facilitate implementation of new benefits, and to ensure regular review and updates [43].

c) In health systems with multiple benefit packages, policy makers must ensure coherence across them. Defining clear boundaries between benefit packages both in terms of service entitlements, conditions of access, and the target population, is necessary to reduce uncertainty for both providers and service users, and to minimize inefficiency resulting from overlaps and duplication. Ensuring a coherent set of provider payment mechanisms across schemes is also necessary [44].

d) Where co-payments are implemented these should be simple, have only a small number of categories, and be defined as a low fixed absolute amount. Most importantly, user charges or fees should not be defined as a percentage of the final bill. The resulting uncertainty reduces transparency, as service users do not know their financial liability until the final bill is presented. Uncertainty over financial cost is a significant reason for not seeking care. In addition, percentage co-payments imply that those who need more services will have to pay more, directly contrary to equity objectives.

e) Benefit design must be closely aligned with the different elements of health financing policy and with service delivery objectives. This means ensuring there are adequate revenues to fund defined entitlements, and that public finance and purchasing arrangements explicitly connect the budget with service delivery priorities. Well-designed programme budgets can help improve alignment with priority needs, provide greater flexibility in resource use, and support improved tracking of results [45].
REFERENCES


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