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### **BREADTH AND DEPTH OF BENEFIT PACKAGES: LESSONS FROM LATIN AMERICA<sup>1</sup>**

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Universal Coverage is broadly defined as "access to needed services without the risk of financial hardship". In order to make this definition operational, however, additional questions need to be addressed. Which services are needed? By whom? Who decides which services are delivered with the public budget? More importantly, given that resources are scarce and no country in the world is able to provide all potentially effective services to all the people who might need them, which services should be excluded from coverage?

Publicly financed health care systems have traditionally announced "universal coverage" for all the population, but without specifying in any detail the specific services that are included and excluded. Thus, universal coverage does not mean that all that is needed will be provided. The capacity of the health system, in terms of human resources, medication, technology and infrastructure ultimately determines what is effectively delivered. Decisions of what specific medical services to deliver (and to whom) are usually made locally by physicians, considering medical need and feasible treatment options, but without very explicit or even consistent criteria. To the extent that not everything that is needed is provided, rationing of resources takes place implicitly. The latter is usually not presented or perceived as a service denial but rather as a clinical fact of life (Syrett 2007). The fact that rationing of resources is not visible does not mean, however, that it does not take place.

Alternatively, health systems can offer universal coverage for all the population but be more specific as to what services are included and excluded – by defining a package of

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covered services. A positive list of interventions can be assembled, with the public understanding that whatever is in the list should be provided at publicly funded facilities, and whatever is not in the list will not be provided. Or else, countries (especially wealthier ones) can opt for a negative list of excluded interventions, in the public understanding that whatever is not in the list of exclusions is covered. These lists define explicit benefit packages<sup>5</sup>.

With the latter, resources are rationed with explicit and consistent criteria: inclusions usually consult cost-effectiveness, which assures that the limited available resources are deployed to provide those services that generate the greatest health gain for the whole population. Consistency follows from the fact that if a service is included, it should be provided to anyone who needs it (regardless of capacity to pay), and whatever is excluded for one citizen is excluded for everyone.

Explicit benefit packages give a concrete meaning to the notion of entitlement. Citizens can claim specific services that are included as a right, not as a favor or as an uncertain possibility. Of course, for them to be an entitlement not only the package needs to be in place along with the capacity to deliver it, but citizens need to be made aware of what they are entitled to.

#### **CHALLENGES FOR DEVELOPING COUNTRIES**

On the road to achieving universal coverage, with either implicit rationing or explicit benefit packages, countries face difficult choices. This is especially true for low and middle income countries where resource scarcity is greater.

Health systems that nominally announce “universal and free coverage for all” often deliver much less than is needed. Effective coverage, understood as the delivery of optimal quality services to the populations that need them, often lags behind due to insufficient funding or inefficiencies. When people perceive that the publicly funded system will not meet their health needs they can demand services in the private sector up to their capacity to pay.

The relative share of out-of-pocket spending in the overall financing of health services is related to the extent to which the public system is failing to deliver what is needed. In privately financed health care the inevitable rationing of resources also takes place: in this context exclusions are usually dictated by capacity to pay. Of all the possible ways of rationing resources (implicitly or explicitly) capacity to pay is generally perceived as the most inefficient, inequitable and unfair.

A case in point is Mexico. Until the mid nineties the health system was presented as offering “universal coverage” with public financing and service provision. When evidence became available of the great extent to which Mexicans had to rely on out-of-pocket

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<sup>5</sup> These are often called “basic packages” or “basic plans”, the word basic meaning that not all services but only those deemed essential and affordable are included. This idea should not be confused with basic meaning primary care or low complexity interventions. Basic packages can include primary, secondary or tertiary level services.

services and private provision – about 50% of spending was and is private out of pocket – it became clear that there was a wide and inequitable gap in public service coverage (Frenk, González Block, Lozano et al, 1994). This evidence provided the rationale for a reform process that led to the creation of the Seguro Popular, a social health insurance that entitles citizens to an explicit benefit package and financial protection that will, by 2010/2012 cover all Mexicans who do not have access to social security (Frenk et al., 2006, Knaul et al, 2006; Frenk, Gomez Dantes and Knaul, 2009).

In implementing pure explicit rationing through benefit packages countries can encounter certain difficulties. Colombia, for example, has implemented since the nineties a universal social health insurance scheme with a mandated basic health plan (an explicit benefit package). Services not in the package are, in principle, not provided by the publicly funded health system (for those services, the only option that remains is to pay out-of-pocket). In recent years, however, people have started to challenge these service denials in the Courts arguing that the Constitution includes the right to health. In 2008 the fiscal cost of reimbursement claims for services outside the basic plan amounted to 20% of overall financing for the plan. These extra services are not evaluated on cost-effectiveness grounds and are provided on a one by one basis (legal cases don't constitute precedents). As the whole idea of the basic package is undermined the health system resorts back to implicit rationing mechanisms.

The extent to which the judiciary has been involved in health care resource allocation seems unique to Colombia, and is related to particular features of its legal system. However, it is also related to a more general issue that has been pointed out by political scientists: pure explicit rationing raises the visibility of the hard choices that are inevitably made in any health system and for this reason tends to become politically contentious and unstable. Social acceptability of the necessary limits to service coverage remains a challenge.

Countries can also take a middle ground when facing the dichotomy of implicit versus explicit rationing. Chile is an interesting case in point. Until 2005 there was no benefit package in the health system. In a recent reform process a set of 56 medical conditions, for which medical protocols were developed. For these prioritized conditions a set of explicit guarantees was introduced as an entitlement for citizens, not only in terms of specific services covered but of quality standards (protocols) and maximum waiting times. Now, for the conditions not in this set, services are not denied. People can demand them in public facilities where resources continue to be implicitly rationed as before the reform.

This scheme, called (AUGE6) can be assimilated to setting up a “fast cashier” in the supermarket. For prioritized conditions, there is fast and guaranteed access. For the rest, people have to make the regular queue, where services are generally provided, but there is no explicit guarantee of their provision. This combination can achieve many of the advantages of explicit priority setting, while avoiding the political and social sensitivities associated with pure explicit rationing.

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<sup>6</sup> Acceso Universal con Garantías Explícitas

As health systems across the world advance towards effective coverage evidence is being accumulated on the feasible and equitable ways of giving a concrete meaning to the definition of "access to needed services". The fact that no system can cover everything for everyone that needs it places a limit on the depth of coverage, and there is growing awareness of the need to have a fair and legitimate process for setting these inevitable limits (Daniels 2008).

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