

DESIGNING HEALTH BENEFITS POLICIES

A COUNTRY ASSESSMENT GUIDE



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This guide was produced by the Joint Learning Network for Universal Health Coverage (JLN), a community of policymakers and practitioners from around the world who jointly create practical guidance to accelerate country progress toward universal health coverage.

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Acknowledgments

The editors gratefully acknowledge the generous funding from the Bill & Melinda Gates Foundation that made possible the production of this guide. Other partners contributed valuable technical expertise and created opportunities for exchange that greatly enriched this document. In particular, the editors would like to thank the Joint Learning Fund, the Ministry of Health and Badan Penyelenggara Jaminan Sosial of the Government of Indonesia, and the National Health Insurance Service and Health Insurance Review and Assessment of the Government of South Korea, all of whom helped support joint learning exchanges that informed the information presented here.

The editors would also like to thank the many individuals from JLN countries and international partner organizations who provided specific contributions to the guide by participating in virtual and in-person meetings and developing the assessment process.

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INTRODUCTION

This document offers guidance on assessing a country's health benefits policies and producing a report that offers helpful insights and recommendations. It discusses research methodology and details an eight-step assessment process, as well as the structure and content of the resulting report. Templates are provided for planning and for data collection; these can be adapted to the specific country context.

The assessment process addresses the following questions about a country's new or revised health benefits policies:

- What are the objectives of the policies?
- What decision-making criteria and processes are being used?
- What outcomes are being achieved?
- What are the implementation challenges?

For the purposes of this assessment, health benefits policies are defined as a government's strategy and policies to define a primary health care (PHC) benefits package and ensure access to services in the package. While the assessment focuses on PHC, it may inevitably touch on secondary and tertiary care since health benefits packages often provide these health services without specifying the level of care.

The JLN's PHC Initiative

In 2016, a group of committed country practitioners in the JLN PHC Initiative joined together to share knowledge on how to create effective health benefits policies as well as to address the lack of international guidance in this area. These practitioners formed the JLN Health Benefits Policy (HBP) Collaborative and began sharing experiences and compiling practical advice for use by other low- and middle-income countries. As part of this effort, six countries—Indonesia, Kenya, Malaysia, Mali, Morocco, and Vietnam—conducted assessments to evaluate their own efforts to implement a new or revised benefits package within a comprehensive health benefits policy, using a methodology developed by the collaborative. This guide is based on that methodology. (The resulting country assessment reports and an overview report synthesizing the experiences of all six countries—titled *Designing Health Benefits Policies: Lessons from Six JLN Countries*—are available on the JLN website.)

ASSESSMENT STEPS AND TIMELINE

The assessment process has eight steps. Annex A includes a planning template with questions to consider in each step and a proposed timeline. It can be useful to fill in the template before starting the assessment process, even if the answers are preliminary, because doing so will help identify practical issues that may arise.

- 1) Obtain funding and authorization (Month 1).** The first step is to secure resources and permissions. The institution carrying out the assessment or a local research entity may have funds available to cover staff time and other necessary support. Or it might be necessary to apply for external funding. This is also the time to obtain approvals to conduct the research—from institutional leadership and from any ethics review boards that may oversee research in the country.
- 2) Form and orient an assessment team (Month 1).** The next step is to identify institutions and individuals to carry out the assessment, including a principal investigator and a team of researchers, and to inform them about the background and objectives of the assessment and delegate tasks. If the assessment team is unable to conduct the assessment in a timely fashion, it may hire a consultant to facilitate the work. A qualified consultant must have the analytical skills, relationships with key informants, and expert knowledge to collect and analyze data and write up the results.
- 3) Prepare to collect data (Month 1).** Data collection involves two phases that may be carried out concurrently: document review (secondary data collection) and interviews (primary data collection). The appropriate interview format will depend on the country context, but it should be determined early in the process so the assessment team can adequately prepare. After the team has chosen an interview format, several practical considerations remain before data collection can begin. The planning template in Annex A can help with preparations for both the document review and the interviews.
- 4) Conduct the document review (Month 2).** Document review involves extracting key information from relevant documents assembled by the team.

- 5) **Conduct interviews (Month 2).** Interviews offer an opportunity to learn from key individuals with expert knowledge and experience. They also offer a way to verify and fill information gaps identified during the document review.
- 6) **Analyze and synthesize the data (Month 3).** This step includes triangulating among data sources, including information from documents and interviews, to identify themes, interpret findings, and develop recommendations.
- 7) **Write the assessment report (Months 4 and 5).** This guide provides an outline for writing the assessment report, as well as guidance on who should write the draft and who the reviewers should be. The introductory sections can be drafted before interviews begin.
- 8) **Disseminate the report (Month 6).** Disseminating the assessment report to target audiences—particularly those within the country who have the authority to implement the report’s recommendations—may involve presenting at meetings or conferences or publishing the findings in a journal.

RESEARCH METHODOLOGY

The suggested timeline for conducting the assessment and producing the report is short—about six months. The methodology presented here is therefore not overly burdensome and can quickly yield results.

The assessment process uses a qualitative research methodology that aims to understand processes, experiences, and attitudes by asking “what,” “how,” and “why” questions. The approach begins with broad research questions that can evolve or be refined as the research process moves forward.

As noted earlier, data collection for the assessment involves two phases: a review of available documents (secondary data collection) and interviews (primary data collection).

Ethical Issues

The institution overseeing the assessment may require formal review by an ethics board to safeguard the dignity, rights, safety, and well-being of the research participants. The assessment process presented here generally involves minimal risk to participants. Nevertheless, it is important to address two key ethical considerations: consent and confidentiality.

Consent. It is important to ensure that all individuals who participate in the assessment are doing so freely, without coercion or pressure. They should be well informed about the objectives of the assessment and how their responses will be used, and they should be assured that declining to participate will not adversely affect them. Depending on the institution's requirements, it may be necessary to obtain written consent from interview or focus group participants. At the very least, interviewers should obtain verbal consent from each participant for the interview and for taking notes documenting the conversation.

Confidentiality. It is crucial to protect the confidentiality and privacy of research participants. This principle has implications for how data are collected and stored and for how quotes and sources are cited in the assessment report.

Document Review

A document review can provide an understanding of the context and background of health-sector regulation. Some of the information collected during this stage will be *quantitative* (e.g., number of regulators, budget available to regulatory agencies, number of monitoring visits conducted), and some will be *qualitative* (e.g., what laws and policies are in place, who the main actors are, and what their responsibilities are).

This phase will also help identify what information is available, what the information gaps are, and what types of questions will require additional investigation through interviews.

Relevant material may come from a range of sources, including:

- **Policy and strategy documents**, including the national health-sector strategy and public-private partnership policy statements.
- **Legal documents**, including laws passed by a legislative body, decrees or rules issued by government ministries or agencies, judicial orders issued by courts, and service agreements and contracts.
- **Research studies**, including peer-reviewed journal articles and studies published by nongovernmental organizations, research institutes, and international organizations.

- **Internal and external records**, including annual reports, annual health accounts, monitoring reports, meeting minutes, budgets, and terms of reference.
- **Databases**, including country health management information systems (e.g., DHIS2), finance management information systems, accreditation program tracking systems, and global databases and resources such as www.imf.org/en/data.

The challenge with a document review is to avoid getting overwhelmed by information that is not pertinent to the assessment. It is also important to track the data sources so the resulting report is well cited and credible. It is good practice to note emerging trends, findings, preliminary conclusions, or follow-up questions in a Microsoft Word or Excel document. Coding can be helpful in documenting trends. Some codes can be defined before the document review, and some can emerge from what the team notices in the data.

Interviews

Interviews are conversations that provide data to answer research questions. They offer an opportunity to learn from key informants with expert knowledge and experience, as well as a way to verify and fill information gaps identified during the document review.

Unlike with some studies, which require a random or statistically representative sample, this assessment uses *purposive sampling*, which selects participants based on their knowledge of the topic because they are most likely to provide useful information. To ensure a diversity of perspectives, it is best to begin with a list of important stakeholder groups and then identify key individuals within each group. Another useful technique is *snowball sampling* or *chain sampling*, which involves asking key informants to help identify other individuals with relevant insights. For example, a representative of a regional regulatory body might mention a private-sector facility that is complying with all regulations and a facility that is evading enforcement efforts. Adding staff from these two facilities to the interview list would be an example of snowball sampling.

The size of the sample will depend on the complexity of the questions and the time and resources available to the assessment team. It is best to interview more than one representative of each stakeholder group unless additional interviews are not generating new information or understanding.

Interviews can be structured in different ways, depending on the research objectives:

- **Structured interviews** use a fixed, detailed list of questions with little to no opportunity to deviate from the interview script, including the order of the questions. This approach is typically used to test specific hypotheses or answer narrow research questions and is unlikely to be suitable for this assessment.
- **Semi-structured interviews** use a topic guide that includes specific but open-ended questions and prompts. (See the sidebar below.)
- **Unstructured interviews** use a few general questions to get the conversation started. They work best when little is known about the topic.

Semi-structured interviews are the most suitable format for this assessment because the document review will have yielded useful background information and the flexible structure is helpful for gathering relevant information efficiently.

Developing Topic Guides

A topic guide can help a researcher conduct a semi-structured interview. It includes a standard introduction and conclusion script, a list of questions, and prompts that encourage the interviewee to elaborate on or clarify a response. A topic guide often starts with an icebreaker (e.g., “Tell me about your role at this organization.”) and then transitions from general to specific questions and finally to any sensitive topics. A sample topic guide is found in Annex C.

The list of questions can be informed by trends, themes, findings, preliminary conclusions, or follow-up questions that arose during the document review stage. It may be necessary to develop different topic guides for each stakeholder group (e.g., facility staff, professional associations, district health management teams, national-level health policymakers).

The questions do not need to be asked in the exact order that they appear in the guide, and not all questions must be asked during every interview. Topic guides can evolve as the interview process progresses.

Depending on the sensitivity of the interview topics, the level of detail sought, the availability of key informants, and interviewer skill, the format of the interview can also vary. Table 1 lists the options in increasing order of facilitation required, from written surveys to half-day workshops. To achieve the objectives of this assessment, individual and natural group discussions will likely be the most appropriate options.

Table 1. Interview Formats

Format	Definition	Structure	Estimated Duration	Advantages	Disadvantages	Data Collection Method
Written survey	Researcher distributes terms of reference and a written survey to participants	Participants independently complete the written survey based on the interview topic guide	N/A	May increase the chances of getting responses from busy key informants	Does not allow interviewer to give prompts or ask clarifying questions	Participants record written answers in a survey template
Individual interview	One-on-one conversation between an interviewer and a key informant	Semi-structured conversation that follows a topic guide and takes place in person or over the phone	30–60 minutes	Elicits in-depth responses and may be preferable to group discussions if topics are sensitive or controversial	May be time-consuming for researchers to conduct individual interviews with all key informants	Discussion is typically documented by a dedicated notetaker (separate from the interviewer), with or without audio recording
Natural group discussion	Facilitated discussion with two to four individuals from a group that is independent of the research study (e.g., staff who work the same shift at a health facility or in the same unit at the Ministry of Health (MOH))	Semi-structured conversation that follows a topic guide; group may be convened intentionally or evolve from an individual interview (e.g., “Do you mind if my colleague joins?”)	60 minutes	Well-suited for observing group dynamics and norms; can be an efficient use of researcher and key informant time	Group dynamics may result in some participants not contributing their honest observations and opinions	Discussion is typically documented by a dedicated notetaker (separate from the interviewer)
Focus group discussion	Facilitated discussion with 6–10 people who meet sampling criteria	Semi-structured conversation that follows a topic guide and requires a highly skilled facilitator	90 minutes	Well-suited for capturing a broad range of ideas and opinions	Challenging to facilitate and unlikely to yield detailed individual responses; may result in data management burden	Discussions are usually audio-recorded and transcribed for analysis in addition to notetaking during the discussion
Workshop	Facilitated discussion with key informants from several stakeholder groups	Semi-structured plenary and small group conversation that follows a topic guide and requires a highly skilled facilitator	Half day	Captures a broad range of ideas and allows time for in-depth discussion and debate	Can be difficult to schedule and challenging to facilitate	Discussion is typically recorded by a dedicated notetaker and on flip charts

The planning template in Annex A provides a detailed list of practical issues to consider when organizing interviews, including who will schedule the interviews, where the interviews will take place, and whether a translator is needed.

Interviewing Skills

Interviewing requires a set of skills that take practice to develop. Role-playing with colleagues can be especially helpful.

Interviewers must learn to clearly explain the background and objectives of the assessment and respond to questions. They must understand confidentiality procedures and be comfortable asking for and obtaining verbal consent. Interviewers must also thoroughly understand the topic guide, including the purpose of each question and the overall flow of the interview. This will help with transitions from one question to the next and with rephrasing, reordering, or skipping questions as needed.

Here are some additional do's and don'ts for interviewers:

Do	Don't
✓ Conduct the interview in a quiet, comfortable place without distractions, and build rapport using a friendly tone of voice and body language	✗ Bias the interview by presenting your own opinions or perspectives
✓ Adapt the interviewing style to the participant's personality (e.g., animate shy individuals by being warm, and manage dominant individuals by being polite but firm)	✗ Reveal whether you agree or disagree with a given response (e.g., say "thank you" as a neutral way to acknowledge an answer instead of "good" or "that's interesting")
✓ Be flexible under changing circumstances (e.g., an individual interview may evolve into a group interview, or a participant may suddenly need to leave)	✗ Ask leading questions (e.g., say "Tell me how you reacted to the new regulation" instead of "Did you oppose the new regulation because it affects your profit margin?")
✓ Ask concrete but open-ended questions focused on how and why (e.g., "Tell me about the most recent monitoring visit at this facility" instead of "What do you think of facility monitoring?")	✗ Ask judgmental questions (e.g., say "How did you decide whether to conduct the monitoring visit?" instead of "Why didn't you show up for the monitoring visit?")
✓ Be an engaged listener and allow participants time to think before responding	✗ Interrupt, speak too rapidly, or jump too quickly from one subject to another
✓ Repeat back what you have heard to ensure that you have understood the participant, if necessary	✗ Correct or dispense advice to the participants
✓ Ask one question at a time	✗ Ask too many "yes" or "no" questions

Translation

If a translator is needed during interviews, choose a translator that is trusted by participants. Gender dynamics and other cultural sensitivities are important to consider. The translator should also understand the topic guide and any technical terms that might arise. The translator should be directed to provide literal sentence-by-sentence translations, not summaries or interpretations. The interviewer should maintain eye contact with the participant, not the translator, during interviews.

Audio Recording and Notetaking

Audio recording is not recommended for purposes of this assessment because it adds an additional transcription step after the interview. Using a dedicated notetaker is more efficient. If audio recording is used, however, the interviewer must obtain advance permission from participants, explaining that the rationale for recording is to accurately document and report their views. The best way to ensure accurate transcription is to have the transcriber present as a notetaker during the interview so the transcriber has a draft to work from and has context in case portions of the audio recording are unclear.

If any participant does not consent to audio recording, a notetaker must be used instead.

The following are good practices for notetaking:

- When handwriting notes, begin each entry with the date, time, place, and type of data collection event (e.g., individual interview).
- Use wide margins to make it easier to expand the notes at a later time. Or use a blank topic guide with space reserved for responses.
- Use abbreviations and shorthand to capture key information quickly and accurately—do not worry about spelling or grammar or capturing direct quotes.
- Reread, organize, and expand on the raw notes soon after the interview. This might mean typing handwritten notes, expanding shorthand into sentences, filling in information gaps, or correcting misspellings.
- Confer with the interviewer soon after the interview ends to agree on two to four highlights or key messages from the interview. The interviewer can use these in writing a brief thank-you email to the participant within two days of the interview. This shows respect for the person's time and facilitates the beginning of analysis.

Data Collection Software

Several software packages are available for storing, annotating, and analyzing qualitative data using a method called *coding*. Mastering the software can be time consuming, and the cost can be high. For projects with relatively small data sets, such as this assessment, software is likely not worth the investment. As with the document review, the assessment team can do simplified coding by simply highlighting and marking up interview notes with preset codes or codes that are developed during the process of reviewing notes. However, if members of the team have affordable access to coding software and the requisite skills, they should feel free to use them.

Confidentiality

It is important to take reasonable measures to safeguard the confidentiality of participants—even when the topic of an interview is not controversial or sensitive or when participants have given you permission to quote or cite their remarks. This is particularly true if you have collected identifying information such as name and job title.

Protecting confidentiality starts during data collection. In addition to obtaining permission to take notes or make an audio recording, the interviewer should clearly explain to participants how the information will be used and offer them an opportunity to ask questions, raise concerns, or decline participation. Data should also be stored in a secure manner. Notes should not be left out in the open or saved in unprotected computer files. Finally, the assessment report should generally not attribute opinions or remarks to anyone by name.

ANALYZING AND SYNTHESIZING DATA

After the document review and interviews are completed, it's time to analyze and synthesize the *findings* to generate *conclusions* and *recommendations*. These three terms are often used interchangeably, but the distinctions are important, as shown in Figure 1, which includes samples of each in *italics*. The assessment report will include all three.

Figure 1. Findings, Conclusions, and Recommendations



<p>Findings: Straightforward descriptions of evidence from documents or interviews, with little or no interpretation</p> <p><i>Several respondents complained about their lack of ability to enforce existing regulations.</i></p>	<p>Conclusions: Interpretations of the findings to address the research questions</p> <p><i>Enforcement capacity is a major obstacle to effective regulation—it was the most-cited problem in reports and interviews.</i></p>	<p>Recommendations: Suggestions for action based on the findings and conclusions</p> <p><i>Officials with regulatory enforcement responsibility should be given additional resources to carry out their duties.</i></p>
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The most useful findings are common issues that occur across data sources and the main themes that describe the data set. The following steps describe how to conduct a *thematic analysis* to identify important findings:

- 1) **Read and annotate notes/transcripts.** Conduct a preliminary analysis of the document review notes and interview notes as soon as possible after data collection and annotate them with comments, key words, descriptive analyses, and follow-up questions. Clearly mark these annotations as researcher analysis (not participant responses).
- 2) **Identify themes.** Review the annotations made in step 1 and list common themes. These themes should be somewhat abstract rather than summaries of the text. For example, they might include “staff autonomy” or “political will.”
- 3) **Develop a coding scheme.** From the initial list of themes, develop a coding scheme with associated numbers or colors. For example, the scheme might use a code for each stakeholder group so 1 = private-sector providers, 2 = staff autonomy, and so forth. The coding scheme can evolve as categories emerge during the analysis.
- 4) **Code the data.** Apply the coding scheme to the entire data set. This can be done by writing codes in the margins of transcripts, using color-coded manual highlighting, or using the comments or highlighting features in a word processing program. Note that the same line of data may be associated with several different codes.

- 5) **Cut and paste.** After the coding is complete, divide the text into separate documents based on the codes. For example, all sections of text coded as “incentives” would be gathered into one document using word processing software and then reviewed for patterns that can inform conclusions and recommendations. During this stage, it is vital to record the original source of the data.

It can be beneficial to also look closely at the story or narrative within each interview. Does one particular interview exemplify one or more of the themes that have emerged? If so, spotlighting this story could help bring the assessment findings to life.

Next, it is important to validate the strength and accuracy of the findings. There are two main approaches for validating findings:

- **Group-to-group validation.** This approach looks at three factors: 1) how many participant groups mentioned the topic, 2) how many people within each group mentioned the topic, and 3) how much enthusiasm the topic generated among participants. A topic that meets group-to-group validation criteria will have generated a consistent amount of enthusiasm among a consistent portion of the participants across nearly all groups.
- **Triangulation.** This approach involves comparing findings across different data sources. For example, are interview results confirming what evidence in the extant literature suggests, and vice-versa? If so, the findings are likely relevant and accurate. Note, however, that differences across the data sources may also be findings in themselves. Examining “deviant cases” that do not align with the initial findings can prove illuminating.

Conclusions and Recommendations

Conclusions should always be grounded in findings—the straightforward information found in documents and conveyed in interviews. An evidence-based conclusion will, in turn, result in more informed policy recommendations or suggestions for action. The upcoming section includes detailed guidance on generating conclusions and developing recommendations.

Further Reading

Brikci, N., and J. Green. 2007. *A Guide to Using Qualitative Research Methodology*. London: Médecins Sans Frontières. <http://fieldresearch.msf.org/msf/handle/10144/84230>

Mack, N., and C. Woodson, et al. 2005. *Qualitative Research Methods: A Data Collector's Field Guide*. Research Triangle Park: Family Health International. www.fhi360.org/sites/default/files/media/documents/Qualitative%20Research%20Methods%20-%20A%20Data%20Collector's%20Field%20Guide.pdf

WRITING THE ASSESSMENT REPORT

The tables and questions provided in this section can help assessment teams collect and organize data, analyze and synthesize data, and write a structured report. The teams should feel free to add or ignore questions as appropriate.

The following outline lays out the main sections of the report. The assessment team can add to it or omit sections to suit the country context.

1) Introduction

- a) Assessment context and unit of analysis

2) Health Benefits Policy Objectives

3) Formulation of the PHC Benefits Package

- a) Primary beneficiaries
- b) Scope of the benefits package
- c) Processes used to develop the benefits package
- d) Criteria for determining included services
- e) Major stakeholders involved in designing the benefits package

4) Engagement with the Six Implementation Domains

- a) Financing: Mobilizing and Pooling Resources
- b) Financing: Payment Mechanisms
- c) Supply-side Strengthening
- d) Generating Demand
- e) Protocols and Pathways
- f) Accountability Mechanisms

- 5) **Conclusions**
- 6) **Recommendations**
- 7) **References**

Introduction

The introduction should briefly summarize the background, objectives, and scope of the assessment; the structure of the report; the methodology used for data collection and analysis; and the types of documents and data reviewed. It should also specify the number of key informant interviews conducted and the number of focus group discussions (if any).

Here are the key questions the introduction should answer:

- What is the scope of the assessment? Is it existing health benefits policies or ongoing health benefits policy design or reform efforts?
- What was the health system structure before the reform effort? This could include major policy initiatives, public system decentralization, the role of the private sector, and major donor activities.
- What was the health benefits package before the reform effort? Describe any programs covering distinct segments of the population, and note any specific patient populations (e.g., pregnant women, children under age 5) that were exempt from user fees or cost sharing for critical categories of service.
- What motivated the reform effort? Describe the political climate, including any politicians claiming an electoral mandate for reform, political actors involved in the health care market advocating for reform, or public opinion surveys showing dissatisfaction with current PHC benefits policies.
- What other information is useful for understanding the context for reform? Describe health-system-related indicators (such as health financing by source, demography, education, or sanitation) that might provide important context not included in the rest of the report.

Using Table 2, document the country's key health and demographic indicators. Include this table in the report.

Table 2. Demographic and Health Outcome Indicators

Indicator	Measure	Year	Source(s)
Per capita income (PPP)	US\$: Local currency:		
Total population			
Dependency ratio ¹			
Urban and rural population (%)	Urban: Rural:		
Poverty rate			
Infant mortality rate			
Maternal mortality ratio			
Top three illnesses that create demand for health services			
GDP growth rate (past 5 years for which data are available) ²	%:		
Total health expenditure (THE) per capita	US\$: Local currency:		
General government health expenditure as a share of THE ⁴	%:		
Out-of-pocket expenditure on health per capita and as a share of THE	US\$: %:		
Proportion of population with coverage for essential health services	%:		
Proportion of population with large household expenditures on health as a share of total household expenditures/ income	%:		
Degree of government decentralization (e.g., federal system with primary responsibility for health at the local level)			

¹ Age-population ratio of dependents (people younger than 15 or older than 64) to the working-age population (those aged 15–64). See <https://www.arcgis.com/home/item.html?id=5b39485c49c44e6b84af126478a4930f>.

² Usually available from Ministry of Finance and Central Bank websites or from <https://www.imf.org/en/data>.

Health Benefits Policy Objectives

This section of the report describes the objectives of the health benefits policy reforms and how effectively those objectives have been met or how policymakers will measure the success of reforms. Tables 3 through 5 can be helpful for collecting information about the objectives and how policymakers define and measure success.

The HBP Collaborative’s Health Benefits Policy Framework (Annex D) defines six common objectives for health benefits policy reforms:

- **Health Outcomes:** improving population health
- **Financial Protection:** limiting the burden of health care costs borne by patients
- **Quality:** improving the quality of care
- **Efficiency:** improving the cost effectiveness of health care services
- **Sustainability:** improving the health system’s financial viability by ensuring alignment between the services covered and available financing streams and by lowering long-term total health care expenditure growth
- **Equity:** ensuring that priority health services of good technical quality are available for all those in need, irrespective of economic, geographic, gender, ethnic, or other characteristics

Using Table 3, note sources (e.g., government documents, white papers, academic articles, stakeholder discussions) that document the objectives of health benefits policy reforms, the methodology used, and the main findings. Include this and subsequent tables in the report.

Table 3. Health Benefits Policy Objectives Sources

Source	Methodology Used	Main Findings

Using Table 4, note sources that assess aspects of the health benefits policy and briefly describe the methodology used and the main findings. If no sources are available, explain why.

Table 4. Health Benefits Policy Assessment Sources

Source	Methodology Used	Main Findings

Using Table 5, estimate the relative importance of each health objective in the HBP Framework to the reform leaders (those who initiated the reform).

Table 5. Relative Importance of Health Objectives

Health Benefits Framework Objective	Reform Objective? (yes/no)	Priority Level (1 = lowest priority, 10 = highest priority)
Health outcomes		
Financial protection		
Quality		
Efficiency		
Equity		
Sustainability		

Include any available source documents as annexes in the report.

Formulation of the PHC Benefits Package

This section of the report documents what is in the PHC benefits package and how the government created (or is creating) it, including:

- Primary beneficiaries
- Scope of the benefits package
- Processes used to develop the benefits package
- Criteria for determining included services
- Major stakeholders involved in designing the benefits package

Tables 6 through 10 can be helpful for collecting information for this section of the report.

Using Table 6, identify the targeted beneficiaries of the PHC benefits package. For each population, cite source(s) that document their inclusion, where possible—such as a law, a speech, or a political memo—and include any stated rationales for their inclusion.

Table 6. Primary Beneficiaries

Target Group or Population	Rationale	Source(s)

Using Table 7, document any studies, white papers, or data that were used in defining the PHC benefits package and how their findings were applied.

Table 7. Sources Used to Define the PHC Benefits Package

Research Study	Purpose of the Study	How the Study Results Were Used in Designing the Benefits Package	Entity That Used the Results

Using Table 8, summarize and rank the importance of the criteria used to define the services in the benefits package. Consider the studies listed in Table 7 and any other sources that influenced the design of the benefits package (such as news accounts or speeches).

Table 8. Criteria for Determining Included Services

Criterion	Used (yes/no)	Ranking 1 = top criterion (use for only one) 2 = secondary criteria (can use multiple times) 3 = also considered (can use multiple times)
Cost effectiveness		
Total cost		
Burden of disease		
Fiscal/budget impact		
Consumer preferences		
Financial protection		
Reduce out-of-pocket spending		
Focus on prevention		
Political or legal mandate to include specific services		
Other (specify)		

Using Table 9, document the institutions and individuals that participated in outlining the PHC benefits package.

Table 9. Benefits Package Design Participants

Participant	Major Activities and Dates (e.g., analysis, proposed lists of services, town halls)	Role (e.g., designed or conducted analyses, organized workshops or town halls)

Using Table 10, document the actual or proposed timeline for development of the benefits package, including the start date, key intermediate dates, approval date, and the start of implementation. (It might be useful to use a GANNT chart.³)

Table 10. Timeline for Developing the Benefits Package

Key Activity	Process Start Date	Process End Date	Implementation Date

Using the information collected in Tables 6 through 10, write a summary of the scope of the PHC benefits package. The following questions can be helpful in drafting this section of the report. (Some questions do not apply to countries that are still in the process of formulating their PHC benefits package.)

³ For a description of a public health GANTT chart, see www.health.state.mn.us/divs/opi/qi/toolbox/gantt.html#example. For a template of a public health GANTT chart, see <http://asq.org/sixsigma/tools-exchange/docs/gantt-chart.xls>.

- How comprehensive are the service offerings? For example, do they include a broad set of health benefits, or do they consist of “essential” services only? (Include the list of services in an annex or provide a link to a website showing the list.)
- How is the PHC benefits package structured? For example, is it structured around diagnoses and conditions, medical procedures and services, or facility level (including community-based care)?
- How detailed are the descriptions of covered services? For example, do they include specific medical goods and services? Or does the policy simply list services that are not covered or define broad categories of care?
- Are pharmaceuticals included in the benefits package? If so, does the policy include essential drugs lists, formularies, preferences for generics, or other means of prioritizing different pharmaceutical products?
- What changes have been made to the benefits package in response to stakeholder concerns?

Engagement with the Six Implementation Domains

This section of the report describes whether and how countries have addressed how the PHC benefits package interacts with the six policy domains identified in the Health Benefits Policy Framework:

- Financing: Mobilizing and Pooling Resources
- Financing: Payment Mechanisms
- Supply-side Strengthening
- Generating Demand
- Protocols and Pathways
- Accountability Mechanisms

The following questions, along with Tables 11 and 12, can be helpful for documenting how policymakers have engaged with the six policy domains. (Provide financial figures in U.S. dollars, using the current exchange rate, and ignore any questions that are not applicable to the country context.)

Financing: Mobilizing and Pooling Resources

- What process has the national government used in raising and allocating revenue for PHC benefits package services?

- What continuous or new sources of revenue (general taxes, social security contributions, mandatory or voluntary contributions) are used to pay for the services in the benefits package?
- What has been the budgetary impact of the benefits package on government and household expenditures? Provide answers in U.S. dollars and as a percentage of total health expenditure.
- How, if at all, have financial constraints limited the services included in the benefits package?

Financing: Payment Mechanisms

- What new mechanisms have been adopted to pay health care providers, or what new forms of strategic purchasing have been implemented to accomplish the objectives of the benefits package reforms?
- How have the reforms changed the PHC provider payment environment?
- How have policymakers responded to opposition from payers or providers who have been affected by changes (in their costs or revenue stream, respectively) due to the reforms?

Supply-side Strengthening

- To what extent have providers had the capacity to deliver services in the benefits package?
- Describe the capacity of providers to supply all services included in the benefits package.
- How have policymakers supported providers that are unable to handle changes in demand for PHC services?
- Describe the degree of patient choice in selecting a provider, and how patient choice has changed due to the reforms (including changes in the provider network).

Generating Demand

- How have policymakers implemented activities to generate demand for the benefits package?
- Describe policymakers' outreach and enrollment strategies.
- What methods have been used to increase services that have been underutilized (particularly among disadvantaged populations such as rural residents, minorities, and low-income families)?
- What services have been added to achieve health objectives such as prevention and health promotion?

Protocols and Pathways

- What standard treatment protocols or integrated care/referral pathways have been developed to support reform objectives?
- Use Table 11 to document the standard treatment guidelines (STGs) that policymakers have used to ensure a minimum standard for care, including the categories of service. If the STGs are listed on a website, cite the link.

Table 11. Categories of Service in the Standard Treatment Guidelines

Category of Service	Source(s)

- Use Table 12 to document how policymakers have defined maximum wait times for the delivery of benefits package services.

Table 12. Wait Times by Category of Service

Category of Service	Wait Time	Source(s)

- Describe the integrated care/referral pathways to secondary and tertiary care.

Accountability Mechanisms

- What accountability mechanisms are in place for the health benefits package? (Include regulations or agencies that verify benefits package compliance, and agencies that evaluate the impact of the benefits package.)

- What is the process for certifying and licensing providers that deliver the PHC benefits package?
- What institution are responsible for monitoring and evaluating the achievement of health policy objectives?
- How have policymakers overcome opposition from stakeholders (such as providers or health care purchasers) regarding new compliance regulations?

Conclusions

This section of the report synthesizes all of the previous sections and identifies successful approaches, challenges encountered, and lessons learned from implementing the health benefits policy.

The following questions can be a helpful guide:

- What are the major successes and weaknesses of the health benefits policy?
- To what extent have actions taken in the supporting policy domains contributed to the successes?
- Have missed opportunities in the supporting policy domains hindered the success of the reforms?
- What could policymakers have done differently to accomplish the health objectives of the benefits package?
- What tools or resources have policymakers created that would be helpful to other countries that are reforming their PHC benefits package? (Examples might include advertising campaigns, STGs, regulatory mapping, budgetary projections, drafted legislation, and landscape analyses of other countries.)

Recommendations

This section of the report identifies approaches for improving health benefits policies that might be helpful to policymakers in other countries who are working on health benefits policy reform.

References

This section should include all source citations, preferably in the form of endnotes rather than footnotes, and should be on a separate page after the end of the main text. Carefully review the accuracy, completeness, and consistency of all citations and use a standard note style. An additional bibliography is not necessary.

ANNEX A. PLANNING TEMPLATE

Implementation Step		Planning Questions	Responses	Proposed Timeline	Questions/ Notes
1	Obtain funding and authorization	Do you anticipate a need for funding to implement the assessment? If so, what expenses do you expect to have?			
		What funding sources might be available?			
		What do you need to do access the funding sources listed above?			
		Does your institution require formal approval from management or leadership before beginning new research studies?			
		Does your institution require ethics review of new research studies? If so, what materials do you need to submit to the review board?			
2	Form and orient a research team	Designate a principal investigator (lead researcher) to manage implementation of the assessment.			
		What institutions would ideally be involved in preparing the assessment? (You will specify their roles in steps 4–8 below.)			
		Will you include a representative of the private sector on the assessment team?			
		What is the capacity of the actors and institutions above to participate in preparing the assessment (e.g., time, expertise)?			
		Do you plan to engage a consultant to assist with preparing the assessment?			

Implementation Step		Planning Questions	Responses	Proposed Timeline	Questions/ Notes
3	Prepare to collect data	Based on the research methodology provided in this document, do you anticipate conducting individual interviews, group interviews, workshops, or focus group discussions?			
4	Conduct document review	What types of documents and records are easily accessible for review?			
		What types of documents and records might be challenging to obtain?			
		Who will identify and then collect relevant documents?			
		How will collected documents be filed and organized?			
		Who will review documents and records, and how will that person keep track of findings?			
5	Conduct interviews	Who will identify potential participants for interviews and/or workshops?			
		How will the potential participants be identified?			
		Who will handle the logistics of interviews and/or workshops (e.g., scheduling, booking the location, ordering refreshments)?			
		Who will conduct the interviews and/or moderate the workshops?			
		Who will take notes during interviews and/or workshops?			
		Will interviews, focus group discussions, and/or workshops be audio recorded? <i>(Note: This approach is not recommended but may be a country preference.)</i>			
		If yes, who will transcribe the interviews?			
		How will interview notes/transcripts be organized?			

Implementation Step		Planning Questions	Responses	Proposed Timeline	Questions/ Notes
		Who will complete the tables and answer the questions in the assessment guide?			
6	Analyze and synthesize the data	Who will analyze the data?			
		How will the data be analyzed (e.g., cross-referencing documents and interviews)?			
		Who will synthesize the conclusions and develop recommendations?			
		How will conclusions and recommendations be validated (e.g., stakeholder workshop, assessment review process)?			
7	Write the assessment report	Who will write the draft assessment report?			
		Who will review and provide comment on drafts of the assessment report?			
		Who will proofread and format the assessment report?			
8	Disseminate the assessment report	How will you validate the findings of the assessment before publication of the report?			
		Who will approve the final assessment report for publication?			
		How do you plan to disseminate the final assessment report within the country?			
		Who will be the target audiences of the assessment?			
		How will you ensure that the assessment translates to follow-up action?			
		How will you obtain funds for dissemination efforts?			

ANNEX B. SAMPLE CONSULTANT SCOPE OF WORK

Assessment of Private Health-Sector Regulation in [COUNTRY]

Assessment Objective

The objective of this country assessment is to document the following:

- What types of regulations govern the private health sector in [COUNTRY]
- How have private health-sector regulations been implemented in [COUNTRY]
- What outcomes are achieved by regulations implemented in [COUNTRY]
- What resources are available for developing and implementing regulations in [COUNTRY]

Consultant Scope of Work

The Consultant will work in close collaboration with the country assessment team and technical facilitators to implement the assessment by carrying out the following tasks:

- Adapt the assessment guide to the local setting
- Review research documents and conduct qualitative data collection
 - Identify stakeholders to collect data from
 - Select the method of qualitative data collection (e.g., individual interviews, workshops, focus groups)
- Analyze and synthesize the data collected
- Draft and finalize the assessment report, which will include tables, charts, and narrative to summarize the findings as laid out in the assessment guide
- Present the results to interested stakeholders

Desired Qualifications

- Extensive knowledge of the health system, health system regulation, and private health sector in [COUNTRY]
- Experience with qualitative research design, data collection, and analysis, including conducting key informant interviews and focus group discussions
- Experience leading and facilitating research teams
- Excellent oral and written communication skills in the local language and in English

- Excellent Microsoft Office skills
- Proven ability to develop effective working relationships with government officials at all levels, local organizations, and other program partners
- Keen ability to anticipate next steps, demonstrate initiative, exercise discretion, apply sound judgment, and work well both independently and collaboratively as a member of a team

ANNEX C. SAMPLE TOPIC GUIDE

Standard Introduction

- Thank you for taking the time to meet with us today. Our names are [NAMES], and we work at [ORGANIZATION], focusing on [DESCRIPTION OF WORK].
- We are conducting an assessment of health-sector regulations in [COUNTRY] to help the government engage more effectively with the private sector and increase access to primary health care services.
- As part of this work, we are conducting interviews with a number of stakeholders involved in developing and implementing health-sector regulations, as well as stakeholders affected by health-sector regulations.
- We have a list of questions we'd like to ask you, and we encourage you to be candid with your answers and comments. There are no right or wrong answers—we are simply looking for your opinions and perspectives.
- We aim to keep this interview to [XX minutes]. Your responses will be kept private, and notes from the discussion will not be shared with anyone outside of our research team. Any information you provide will be combined with information collected from various other sources and will not be attributed to you personally. Your participation is completely voluntary.
- We would like to take notes during our discussion to ensure that we accurately capture the information and views you share. These notes will be for our team's use only. Is this okay with you?
- Do you have any questions for me before we begin?

Illustrative Questions

- 1) **Icebreaker:** To start, please describe your role at [UNIT/DEPARTMENT/AGENCY/ORGANIZATION].
- 2) **Question 1 (General):** Tell me about the most successful monitoring visit you have conducted in the past year.
 - a) **Prompt 1:** What factors made the visit so successful?
 - b) **Prompt 2:** What policy changes would be needed to replicate this success?

- 3) **Question 2 (Specific):** How, if at all, has the amount of resources available to support monitoring visits changed over the past year?
- a) **Prompt 1:** Have more staff been assigned to the unit?
 - b) **Prompt 2:** Has the unit's budget increased?
 - c) **Prompt 3:** Has additional equipment, such as vehicles or tablets, been acquired?

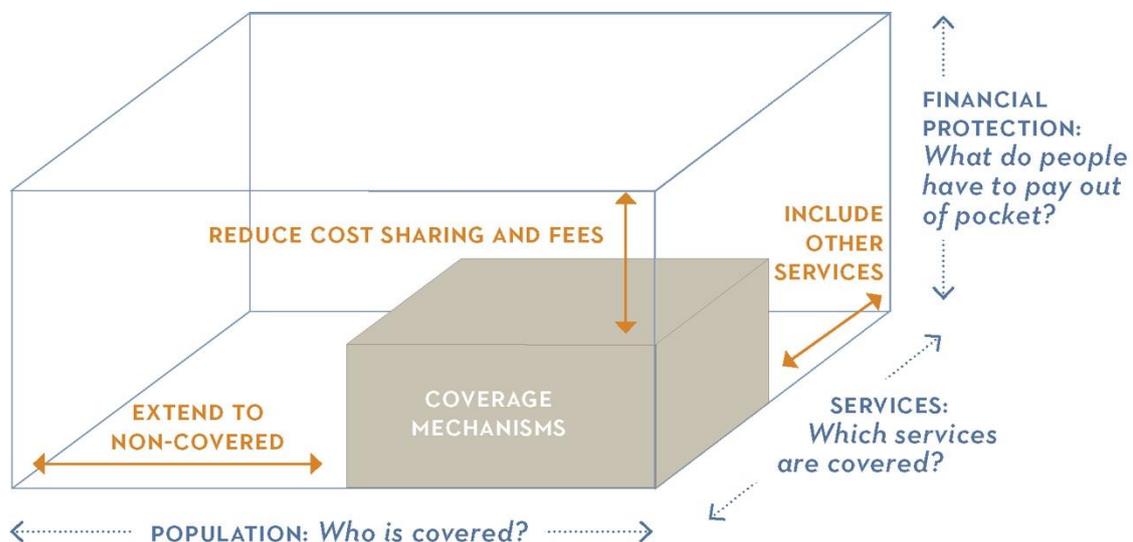
Standard Conclusion

- Thank you. Those are all the questions I have. Is there anything else you would like to add?
- [To NOTETAKER] Are there any points you'd like to clarify before we conclude the interview?
- Thank you again for your time and your willingness to speak with us today.
- We expect to publish this assessment report in [DATE].
- In the meantime, don't hesitate to contact us with any questions.

ANNEX D. DESIGNING HEALTH BENEFITS POLICIES TO PROMOTE PRIMARY HEALTH CARE

Countries that are dedicated to achieving UHC want a scheme that covers all individuals, but covering a full suite of medical services for the entire population is often impractical and would exceed available resources. Tradeoffs are inherent in all coverage schemes, and for countries in the HBP Collaborative, these tradeoffs have included which services to cover, which populations to cover, and how much covered individuals should pay out of pocket for services. (See the figure below.)

Dimensions of Universal Health Coverage



Because all countries have resource limitations, the design of the health benefits package must take into account the financial, technical, and economic capabilities of the country's health system. Failure to account for country capacity can lead to implicit rationing that does not align with country priorities. Not only should the benefits package be scaled to available resources and capacities, but the health system that implements the package should be coordinated in a way that enables covered services to be accessed by beneficiaries—either through providers or through public health interventions.

Helpful Resource for Designing Health Benefits Policies

[Designing Health Benefits Policies: Lessons from Six JLN Countries](#)

In 2016, a group of committed country practitioners in the JLN PHC Initiative joined together to share knowledge on how to create effective health benefits policies as well as to address the lack of international guidance in this area. These practitioners formed the JLN Health Benefits Policy (HBP) Collaborative and began sharing experiences and compiling practical advice for use by other low- and middle-income countries.

The HBP Collaborative created a framework to guide policymakers in considering the potential objectives of benefits package creation and the complementary policy domains that enable the benefits policies. The framework, depicted below, is based on global best practices for creating and implementing health benefits packages that are appropriate to each country's unique health system.



The PHC Benefits Policy Framework offers a way to understand the considerations involved in designing a PHC benefits package and the overall health benefits policies. At the center of the framework is the benefits package. The choice of services to include in the package is the common starting point for countries that want to improve access to PHC services. The outermost circle shows the objectives commonly stated by policymakers for PHC-oriented reforms. The inner circle lays out the complementary policy domains that enable implementation of the benefits package to advance PHC objectives.

Objectives of PHC-Oriented Reforms

A country's specific objectives will inform how the package is formulated and implemented. The HBP Collaborative identified six of the most common objectives of PHC benefits package reforms:

- **Health Outcomes:** improving population health
- **Financial Protection:** limiting the burden of health care costs borne by patients
- **Quality:** improving the quality of care
- **Efficiency:** improving the cost-effectiveness of health care services
- **Sustainability:** improving the health system's financial viability by ensuring alignment between the services covered and available financing streams and by lowering long-term health expenditure growth
- **Equity:** ensuring that priority health services of good technical quality are available for all those in need, irrespective of economic, geographic, gender, ethnic, or other characteristics

Countries will have different priorities with respect to the six policy objectives. For example, some countries may place a greater emphasis on equity while others may ascribe more importance to quality of care. Health benefits policies should be consistent with each country's stated policy objectives.

Policy Domains

To accomplish PHC objectives, policymakers not only need to define the benefits package, but they also need to implement the package through a set of enabling policies. The PHC Benefits Policy Framework groups these policies into six domains:

- Financing: Mobilizing and Pooling Resources
- Financing: Payment Mechanisms
- Supply-side Strengthening
- Generating Demand
- Protocols and Pathways
- Accountability Mechanisms

The following table describes each domain and provides policy examples.

PHC Benefits Policy Domains

Policy Domain	Definition	Policy Examples
Financing: Mobilizing and Pooling Resources	The strategy for generating adequate financial resources to finance service delivery	<ul style="list-style-type: none"> • Introduce premiums (monthly, quarterly, or annual contributions from beneficiaries of the benefits package) into the coverage scheme for PHC services • Earmark a tax or a portion of a tax to finance PHC services • Allocate a share of government health spending to fund PHC services
Financing: Payment Mechanisms	Mechanisms that create incentives for providers to offer PHC services	<ul style="list-style-type: none"> • Use a blended provider payment mechanism for PHC to achieve desired objectives • Introduce consumer cost sharing for lower-priority care • Consolidate multiple payers to harmonize purchaser rate setting
Supply-side Strengthening	Government spending to improve provider capacity to deliver high-priority PHC services	<ul style="list-style-type: none"> • Modify laws to change the scope of practice for various medical specialties to enable task shifting • Assess provider readiness to deliver PHC services and fill gaps in training, staffing, and equipment • Build, equip, and staff new PHC facilities in places with limited physical access to care • Offer private providers payment for delivering benefits package services
Generating Demand	The strategy for educating the public about the health advantages of enrolling in the scheme and seeking PHC services	<ul style="list-style-type: none"> • Conduct outreach and education campaigns to inform the population about benefits package services and enrollment • Create and fund mechanisms to promote enrollment in the scheme • Engage civil society organizations when determining the composition of the benefits package in order to promote awareness of the new or modified set of services

Policy Domain	Definition	Policy Examples
Protocols and Pathways	The treatment protocols and referral pathways that improve the quality and efficiency of service delivery	<ul style="list-style-type: none"> • Develop or update standard treatment guidelines • Create primary, secondary, and/or tertiary referral networks • Link payment with provider adherence to protocols and pathways • Develop and implement portable electronic medical records
Accountability Mechanisms	The institutional framework for measuring access and evaluating provider delivery of covered services within the PHC benefits package	<ul style="list-style-type: none"> • Provide oversight of accreditation • Ensure a transparent process for setting priorities in the benefits package • Provide government funding for program evaluation grants • Provide government oversight of compliance with treatment guidance • Publish data on public websites on the use, cost, and quality of benefits package services and on benefits policy performance indicators

ANNEX E. KEY TERMS

accreditation. A formal process by which a recognized body, usually a nongovernmental organization (NGO), assesses and recognizes that a health care facility meets applicable predetermined and published standards.

capitation. Payment to a health care provider based on an agreed-upon amount per person covered or enrolled for a specified package of covered services.

contact rate. The proportion of enrolled patients who had some contact with the provider.

cost sharing. The share of service payment covered by insurance that individuals have to pay out of their own pocket. This generally includes deductibles, coinsurance, and copayments or similar charges but does not include premiums.

cost-effective. In terms of medical treatment or health policy, achieving better or the same outcomes at a lower marginal cost. See also *efficiency*.

credentialing. The process of obtaining, verifying, and assessing the qualifications of health care providers to authorize them to provide specific patient services.

diagnostic or bundled payment. A fixed payment to a health care provider to cover aggregate costs over a specific period to provide a set of services that have been broadly agreed upon. The payment may be based on inputs, outputs, or a combination of the two.

efficiency. In health care, usually improved cost-effectiveness of care. This can be measured by indicators such as avoidable hospitalizations or unnecessary C-sections. See also *cost-effective*.

enrollment. The process through which an approved applicant is signed up for coverage with a health insurance provider.

health benefits policies. Policies that facilitate the development or reform of a health benefits package.

health benefits package. A set of basic health services that can be feasibly financed and provided within a country.

out-of-pocket costs. Consumer spending for medical care that is not covered by insurance. These costs include deductibles, coinsurance, and copayments for covered services, as well as all charges for services that are not covered.

patient choice. The ability of individuals to choose a primary care provider. Patient choice has implications for referrals when needed.

PHC benefits framework. The JLN HBP Collaborative's framework to guide policymakers in considering the potential objectives of benefits package creation and the complementary policy domains that enable the benefits policies. The framework is based on global best practices for creating and implementing health benefits packages that are appropriate to each country's unique health system.

pooling. The collective transferring of health revenues to purchasing organizations. Pooling ensures that risks related to financing health interventions for which the need is uncertain are borne by all the members of the pool, not by individual contributors.

referral network. A structured, multidisciplinary care plan that details essential steps and the appropriate facility level for each step in caring for patients with a specific clinical problem. Referral networks have been proposed as a way to translate national care guidelines into local protocols for clinical practice. Also known as an *integrated care pathway*.

standard treatment guidelines. Documented courses of action for providers to follow in treating specific clinical problems. The guidelines usually reflect medical consensus on the optimal treatment options within a health system and aim to influence provider behavior at all levels of care.

task shifting. The delegating of tasks, where appropriate, to less specialized health workers. Task shifting can lower the cost of care by allowing lower-salaried medical practitioners to care for lower-risk patients or participate in less complicated interventions.

vulnerable populations. Demographic groups that are at risk for poor health access and outcomes. These populations can include racial and ethnic minorities, children, the elderly, socioeconomically disadvantaged groups, the underinsured, and people with chronic, serious medical conditions.