DESIGNING HEALTH BENEFIT PACKAGES FOR UNIVERSAL HEALTH COVERAGE — SHOULD COUNTRIES FOLLOW A SECTORAL, INCREMENTAL OR HYBRID APPROACH?

1Rob Baltussen*, 1Gavin Surgey, 2Anna Vassall, 3Ole F Norheim, 4Kalipsa Chalkidou, 5Sameen Siddiqi, 6Aljiba Nouri, 7Sitaporn Youngloung, 8Maarten Jansen, 9Leon Bøhmke, 10Wiya Oortwijn, 11Radboud University Medical Centre, Nijmegen, The Netherlands; 12London School of Hygiene and Tropical Medicine, London, UK; 13University of Bergen, Bergen, Norway; 14The Global Fund, Geneva, Switzerland; 15Imperial College, London, UK; 16Aga Khan University, Karachi, Pakistan; 17Ministry of Health and Medical Education, Tehran, Iran; 18Tehran University of Medical Sciences, Tehran, Iran; 19Mahidol University, Bangkok, Thailand

1§ Sabine Margarete Damerow*, 1§ joint first author; 2# corresponding author

Countries around the world are increasingly rethinking the design of their health benefit package to achieve universal health coverage. Countries can periodically revise their packages by performing sectoral analyses, i.e. by evaluating a broad set of services against a ‘doing nothing’ scenario using a budget constraint. Alternatively, they can carry out incremental analyses, i.e. to evaluate specific services against current practice using a cost-effectiveness threshold. In addition, countries may employ hybrid approaches. This paper compares these approaches in terms of the nature of allocative inefficiencies, quality of analysis, political feasibility of reallocation decisions, and integrated health system analysis. Sectoral analysis is especially suited in contexts with large allocative inefficiencies in current service provision and can, in theory, realize large efficiency gains. However, it may be challenging to implement a comprehensive redesign of the package in practice. Incremental analysis is especially relevant in contexts where specific new services raise challenges to the allocative efficiency and sustainability of the health system. It may potentially support efficiency improvement, but its focus has typically been on new services while existing inefficiencies remain unchallenged. The use of hybrid approach may be a way forward to address the strengths and weaknesses of sectoral and incremental analysis.

MONITORING THE IMPACT OF HEALTH SYSTEM STRENGTHENING FOR MATERNAL AND CHILD MORTALITY

1Sabine Margarete Damerow*, 1Vegard Mortensvik Lundgren, 2Justinianno Sebastian Dunga Martins, 3Helene Verno Adrian, 4Andreas Møller Jensen, 5Sebastian Nielsen, 6Ane Barent Fikse. 1Bandim Health Project, INDEPTH Network, Bissau, Guinea-Bissau; 2Bandim Health Project, Institute of Clinical Research, University of Southern Denmark, Odense, Denmark; 1Bandim Health Project, INDEPTH Network, Bissau, Guinea-Bissau; 6Aga Khan University, Karachi, Pakistan

Objective To investigate coverage of antenatal care (ANC) and facility births and perinatal mortality before and during the stepwise implementation of the ‘Integrated Programme for the Reduction of Maternal and Child Mortality’ (PIMI), a health system strengthening programme which included free care, health worker training and infrastructure rehabilitation in Guinea-Bissau.

Methods We used data from Bandim Health Project’s rural health and demographic surveillance system from three 24-months birth cohorts: pre-PIMI (2011-13), during PIMI’s pilot phase (2014-16) and its nation-wide full-scale implementation (2017-19); and two areas: pilot regions (PIMI since 2013) and scale-up regions (PIMI since 2017). Using generalized estimating equations, we compared service coverage (first/fourth ANC consultation and facility births) and perinatal mortality over time and across areas. We also assessed associations between perinatal mortality and cluster-level ANC4 and facility birth coverage.

Results Across the three cohorts, 23,828 births were included. Pre-PIMI, approx. 1/3 women obtained ANC4 and facility birth in both areas. ANC4 and facility birth coverage increased to approx. 1/2 in both areas. Relative increases were largest in the scale-up area for ANC4 (p=0.007 for same development), and comparable across areas for facility births (p=0.16). Perinatal mortality was around 8% pre-PIMI and did not decline over time. Higher cluster-level ANC4 (both areas) and facility birth coverage (pilot area) were associated with a tendency towards lower perinatal mortality pre-PIMI, but this association disappeared over time.

Conclusion While universal access to quality maternal and child health services is considered essential to improve maternal-perinatal survival, increases in ANC and facility birth coverage did not translate into reduced perinatal mortality. Hence, measures of health outcomes cannot be replaced by...