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The role of an essential health benefit in health systems in east and southern Africa

This brief presents evidence, learning and recommendations from a regional programme of work in 2015-2017 on the role of essential health benefits (EHBs) in resourcing, organising and in accountability on integrated, equitable universal health systems. It outlines from the regional literature reviews and the case studies implemented in Swaziland, Tanzania, Uganda and Zambia the context and policy motivations for developing EHBs; and how they are being defined, costed, disseminated and used in health systems. EHBs can act as a key entry point and operational strategy for realizing universal health systems, for making clear the deficits to be met and to make the case for improved funding of health systems. The brief points to areas where regional co-operation could support national processes and engage globally on the role of EHBs in building universal, equitable and integrated health systems.

Produced by Training and Research Support Centre with Ifakara Health Institute in association with the ECSA Health Community

A service benefit package for universal coverage

An Essential Health Benefit (EHB) is a policy intervention defining the service benefits (or benefit package) in order to direct resources to priority areas of health service delivery, to reduce disease burdens and ensure health equity.

There have been promising trends in health in the east and southern African (ESA) region, include widening availability of and access to healthcare, especially at primary care level. There are practices facilitating uptake in and providing financial protection for disadvantaged groups, such as through community health workers, community outreach and participation, moving away from fees at point of care and integrating interventions within comprehensive primary healthcare. At the same time, many countries still face shortfalls in meeting key health and health service goals.

As one approach to address the shortfalls many ESA countries have introduced or updated EHBs in the 2000s. Of the sixteen countries in the ESA region, thirteen had an EHB in place by 2016, albeit at different stages of design and implementation, with different stated objectives and referred to by different names.

Various policy intentions were stated by these ESA countries in advancing an EHB. They included: promoting universal access and equity in health; responding and allocating resources to national priority health burdens; promoting cost-effective interventions; advocating for health funding; as a tool for purchasing services or ensuring service delivery; and to clarify and support equitable access to entitlements. ESA countries have applied an analysis of health burdens and cost-benefit or value-for-money of interventions to identify the services included in their EHB, while taking on board policy goals and commitments. Some ESA countries have also taken into account the perceived priorities of stakeholders, external partners and communities. Despite diverse methods being used for their design and costing, the EHBs in the region cover similar services for communicable and non-communicable diseases, maternal and child health and public health interventions and some laboratory, paramedical and allied services, as shown in *Table 1* overleaf.

In all four case study countries, the EHB aimed to provide an integrated service package backed by protocols and service standards. It was found to have a potential role in supporting holistic, sector-wide approaches, including in interaction with other sectors to address their role in health.

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Table 1: Categories included as priority in the EHBs in ESA countries, 2016

COUNTRY	Service Areas Included in the EHB (shaded cell indicates inclusion)						
	Sexual and reproductive health	Maternal and child health	Non-communicable diseases	Communicable diseases	Public health interventions (*)	Specialised clinical, surgery, laboratory services	Allied health interventions (**)
Angola							
Botswana							
DRC							
Kenya							
Lesotho							
Malawi							
Namibia							
Swaziland							
Tanzania							
Uganda							
Zambia							
Zimbabwe							

(*) Includes vaccines, health prevention and promotion, education
(**) Includes laboratory services, blood transfusions, paramedical services and procurement management
Source: Todd, Mamdani and Loewenson, 2016.

The EHB has thus played the role of an aspirational 'universal health benefit', responding to population health needs, clarifying entitlements to comprehensive healthcare services, aligning providers and sectors to their delivery and clarifying the capacity and funding gaps to do so. Resource constraints have, however, motivated rationing of scarce resources, reducing the benefit to a smaller subset that can be funded from current budgets, or from vertical funds. As discussed later, this raises issues of how to set a trajectory to ensure that this 'minimum' benefit package does not become the maximum, to progressively address unmet public health needs.

While resources have thus played a significant role in what the final benefit package includes, the cost estimates calculated for the EHB varied widely across ESA countries. The EHB costings range from $4 to $83 per capita at primary care level and $22 to $519 per capita for higher level referral services. This variation reflects in part the differing assumptions and methods used for capital and recurrent costings. It suggests that regional exchange on costing approaches may be useful, discussed later. However, in all the case study countries, the full EHB package in the public sector exceeded the public sector budget allocation, raising pressures to cost subsets of the package that may feasibly be provided within the budget.

Experiences and promising practices in applying EHBs

Various areas of good practice have been raised in ESA country experience of implementing EHBs. In some countries consultative, consensus-building design processes involved experts and implementers and reached out to parliamentarians and the public. Working groups designed and updated the benefits and costings, and used the EHB as a basis for service guidance and to estimate capacity and financing gaps, linked to national health strategy processes and to sector-wide planning.

Tanzania's EHB has been incorporated into the national health policy, linked to local government and service planning, integrated into guidelines for quality standards and linked to resource allocation and strategic purchasing. Uganda's EHB has also been used to set service guidelines and in negotiations on financing with the treasury and key development partners.

The costings of the EHB have been used to support mobilisation of resources for health services, including through innovative financing. Some countries have ring-fenced funding of the EHB elements. In Uganda, for example, it has guided staff establishments and placements, negotiations for wage support and recruitment of critical service personnel and government resource allocation to districts. The EHB has also been used in policy dialogue on the benefit package for national health insurance and results-based financing.

While the EHB has been used as a tool for local government planning and budgets in the public sector, as noted earlier, it has also been used in some cases to purchase services from private, not-for-profit services through grants. In some countries, such as Uganda, selected indicators of EHB components are used to monitor health sector performance. The EHB has been used as a basis for public sector resource allocation to districts and facilities; to set outputs in performance contracts with referral hospitals and to provide a wider system lens for purchasing. As noted in the case of Uganda, the EHB has also been used in policy dialogue on national health insurance.

Challenges in implementation

Countries also faced challenges in designing and implementing their EHBs. These include:

- The breadth and number of EHB interventions versus available resources and capacities;
- Economic and health budget constraints versus necessary investments for the EHB.
- In the design and monitoring of the EHB there have been limitations in data quality and adequacy of health information and in-country expertise.
- There were difficulties accessing information on off-budget and private sector revenue flows for EHB funding
- There were weaknesses in the involvement of other sectors affecting health and their role in addressing health determinants.

There is still limited evidence of monitoring being used to support the role of the EHB and to publicly demonstrate fair process and social accountability on services. At the same time, the EHB is regarded as a tool to 'correct' some of these weaknesses.

The EHB as a strategic measure for advancing equity and UHC

The findings from the research programme pointed to the potential usefulness of designing, costing, implementing and monitoring an EHB as a key entry point and operational strategy for realising universal health coverage (UHC) and for making clear the deficits to be met in policy dialogue on universal health systems.

From feedback in policy dialogue within the four case study countries, setting an EHB as a universal benefit was seen to be consistent with policy goals to build universal equitable health systems and a potentially useful measure to align public and private actors to these goals. At the same time there is concern that greater profile be given to health promotion and prevention in the EHB. To effectively play these roles, it is suggested that the EHB be updated every five years and linked to national health strategy processes. The processes for its design and use can be used to engage high-level political actors, other sectors and communities early in its design, to build public and political support, to operationalise the interventions and roles for 'health in all policies' and to leverage intersectoral funding for the services in the benefit package.

The EHB and operational guidelines for its delivery are considered a useful standard for planning, budgeting and allocating resources against which to assess and analyse infrastructure, equipment, staffing and other capacity gaps to deliver services. It would thus be useful to link policy dialogue on health financing strategies to EHB requirements and costings, including to support progressive tax financing and pooling of other social insurance and earmarked tax options to avoid segmentation and ensure funds are used for a universal benefit. Beyond such revenue generation strategies, greater attention could be given to ensuring private sector contributions, including through purchasing and performance contracts with non-state services.

Monitoring delivery on the EHB and its system, health, institutional and equity outcomes is observed to build confidence in the design and practice of the benefit, and to inform strategic review and improvement of services. It is recommended that

this be done through investing in and strengthening the existing routine health information and performance monitoring systems, and ensuring that service users, providers, planners and funders receive and discuss the information for improving service performance and outcomes.

Regional co-operation on applying EHBs

There are knowledge gaps in relation to the design and use of EHBs. How are they applied in the private sector? How should communities be included in processes for EHB design, monitoring and accountability? What triggers and transitioning processes should be used to move from 'minimum' to comprehensive EHBs? How should EHBs be framed to address social determinants and to engage other sectors on health?

The exchange across countries in the ESA region highlighted areas where regional co-operation could support national processes and engage globally on the role of EHBs in building universal, equitable and integrated health systems.

It is suggested that it would be useful to have a regional repository of publications and information for exchange across countries to inform EHB processes. There is scope for regional co-operation on training in key skills needed to design and implement EHBs. Regional guidelines could be developed on the roles, design and costing approaches, assumptions and methods and issues to consider in implementing EHBs. It would be helpful to share methods regionally for assessing service readiness and capacity gaps and methods, and to share indicators from the health information system and facility surveys for monitoring performance. National costing processes would benefit from the presence of regional databases of commodity prices and a pool of multi-sectoral expertise on EHB design and costing.

Finally regional exchange on the operational demands of implementing such a comprehensive universal health benefit could be useful both to support national practice, to exchange on good practice and to inform global health negotiations, including on advancing the Sustainable Development Goals and UHC.

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