Regional Network for Equity in Health in east and southern Africa

DISCUSSION Paper NO. 113

The role of an essential health benefit in health systems in east and southern Africa: Learning from regional research

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In the Regional Network for Equity in Health in east and southern Africa (EQUINET) in association with the ECSA Health Community

EQUINET DISCUSSION PAPER 113

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With support from IDRC (Canada)

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EXECUTIVE SUMMARY

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. Many east and southern African (ESA) countries have introduced or updated EHBs in the 2000s. Recognising this in 2015-2017, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), with ministries of health in Swaziland, Tanzania, Uganda and Zambia, implemented desk reviews and country case studies, and held a regional meeting to gather and share evidence and learning on the role of EHBs in resourcing, organising and in accountability on integrated, equitable universal health systems.

This report synthesises the learning across the full programme of work. It presents the methods used, the context and policy motivations for developing EHBs; how they are being defined, costed, disseminated and used in health systems, including for service provision and quality, resourcing and purchasing services and monitoring and accountability on service delivery and performance, and for learning, useful practice and challenges faced.

Generally, the EHBs in ESA countries apply an analysis of health burdens and cost-benefit or value-for-money of interventions to identify services for inclusion, while taking on board policy goals and commitments and perceived priorities of stakeholders, including external partners and, to a more limited extent, communities. Despite the diversity in their design methods, the EHBs in the region cover similar services for communicable and non-communicable diseases, maternal and child health and public health interventions, with some inclusion of laboratory, paramedical and allied services. The cost estimates for the EHBs vary relatively widely ($4-$83/capita at primary care level and $22-$519/capita, including referral hospital services) reflecting in part differing assumptions and methods used for capital and recurrent costings.

The design of EHBs was motivated by different policy agendas. The policy agenda of universal health coverage (UHC) and equity in health motivates an aspirational ‘universal health benefit’ that responds to population health needs, clarifies legal or policy entitlements to healthcare, aligns all providers to national health goals, supports social accountability on services and clarifies capacity gaps for health financing. The funding gap to meet this benefit package has led some countries to explore new revenue sources from innovative financing, linking the EHB to policy dialogue on health financing. Resource constraints and vertical financing have, however, also motivated rationing of scarce resources, reducing the benefit to a smaller subset that can be funded from current budgets. This raises issues of how to set a trajectory to ensure that this ‘minimum’ does not become the maximum and how to address unmet public health needs.

The research raised various areas of good practice in 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. The costings supported mobilisation of innovative financing and resources, while some countries ring-fenced funding of EHB elements. The EHB has been used as a tool for budgeting and planning at local government level, to guide priority setting and budgets and, in some cases, to purchase services from private, not-for-profit services through grants. Health facility reporting on performance on selected indicators of components of the EHB have been used as a basis for public sector resource allocation to districts and facilities; performance contracts in referral hospitals have used EHB outputs; and there is some discussion on the use of the EHB within plans for social health insurance and for direct facility financing. The EHB provides a wider system lens for such purchasing.

Countries also faced challenges in designing and implementing their EHBs: in the breadth and number of EHB interventions versus available resources and capacities; and in economic and health budget constraints versus necessary investments for the EHB. The design and monitoring faced 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, and 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 findings have already begun to feed into policy dialogue within the countries involved. At national level, setting an EHB as a universal benefit is 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, if updated every five years and linked to national health strategy processes. It is suggested that greater profile be given to health promotion and prevention in the EHB, that the process be used to engage high-level political actors, other sectors and communities early in its design, to operationalise the interventions and roles for 'health in all policies', to leverage intersectoral funding for the EHB and to build public and political support.

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. Policy dialogue on health financing strategies was proposed to be linked to EHB requirements and costings, with a preference for 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 and to inform strategic review and improvement. It is recommended that this be done through strengthening the existing health information and performance monitoring systems. While in part this may call for investment in the system, it also calls for processes to engage the range of actors involved in sharing, disseminating and using information in the processes used to design, cost, implement and review the performance and outcomes of the EHB. These include encouraging non-state and external funders and providers to contribute to and use such evidence.

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. This includes having regional repositories of publications and information for exchange across countries to inform EHB processes and regional co-operation on training in key skills areas needed to implement EHB. It was proposed that regional guidelines be developed on the roles, design and costing approaches, assumptions and methods, issues to consider in implementing EHBs, methods for assessing service readiness and capacity gaps and methods and indicators from the health information system and facility surveys for monitoring performance, with links to useful resources. This and regional databases of commodity prices and a pool of multi-sectoral expertise on EHB design and costing would help support national processes, and learning on the operational demands of a universal health benefit could inform global health negotiations.

This research pointed to the evidence within the region for policy dialogue on universal health systems. It raised the usefulness of designing, costing, implementing and monitoring an EHB as a key entry point and operational strategy for realising universal health coverage and systems and for making clear the deficits to be met.

The research also raised knowledge gaps, such as on measures for applying EHBs in the private sector and for community inclusion in EHB processes; the triggers and transitioning processes for moving from 'minimum' to comprehensive EHBs; and how to frame EHBs to address social determinants and to engage other sectors on health. Involving ministry of health personnel as researchers, while demanding for already busy personnel, brought a policy and practical lens, pointing to the value of embedded implementation research to inform strategic policy and service processes.

1. INTRODUCTION

An Essential Health Benefit (EHB) package is a positive (defined) list of benefits, a package of service benefits and a policy intervention designed to direct resources to priority areas of health service delivery. It is intended to reduce disease burdens and to promote equity and efficiency, given limited health resources. In recent years, heightened national and regional attention to achieving universal health coverage as a key goal (SD3) in the Sustainable Development Goals (SDGs), national constitutional commitments establishing entitlements to healthcare and increased pressure on resourcing these policy commitments have drawn further attention to what role defining the benefit package plays in achieving these policy goals.

Recognising this, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), with country partners from ministries of health in Swaziland, Tanzania, Uganda and Zambia, implemented research in 2015-17 to understand how EHBs are being designed and applied in resourcing, organising and in accountability on health services. The work was supported by International Development Research Centre (Canada) and implemented in liaison with the East Central and Southern African Health Community (ECSA HC).

This report synthesises the learning across the full programme of work, integrating findings from a literature review of 16 ESA countries, from country case studies implemented in Swaziland, Tanzania, Uganda and Zambia, and a regional meeting on the findings. The report presents the methods used in the research programme, the context and policy motivations for developing EHBs; how they are defined, costed, disseminated and used in health systems, including for service provision and quality, for resourcing and purchasing services and for monitoring and accountability on service delivery and performance, and the learning, useful practice and challenges faced.

The report highlights the implications of the findings for policy dialogue and practice in the region and the knowledge gaps to address. Country and regional partners reviewed the findings at a regional workshop in November 2017, and the issues and proposals raised have been integrated into this report.

2. METHODS

2.1 The methods used

This report integrates key findings of a regional desk review implemented at the inception of the work (Todd et al., 2016). The study design and protocol were approved by IHI and TARSC, by the Institutional Review Board of Ifakara Health Institute and the National Institute of Medical Research in Tanzania and Tanzania Commission for Science and Technology. Country leads obtained further permissions/clearance to conduct the research within their countries.

The desk review was based on an analytic framework shown in *Appendix 1, Figure 1.* Documents post-1995 and in English were sourced using search terms drawn from the analytic framework from online databases, country websites and Google, Google Scholar and HINARI Pub Med. Eighty-one documents were included, covering sixteen ESA countries (Angola, Botswana, Democratic Republic of Congo, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe).

The desk review and analytic framework identified the terms of reference for the country case studies, in dialogue with participating countries, namely, to:

1. Understand key features of the **EHB purpose and design:** the motivations for their development; the methods and processes used to identify, prioritise and consult on the benefits; to identify the resources, capital and recurrent cost of the benefits; and the facilitators and barriers faced in design and costing of the EHBs.

2. To document the **use of the EHBs**: their dissemination and use in resourcing; strategic purchasing; monitoring performance, delivery and accountability of public and private sector services and the facilitators and barriers faced.
3. To document the **impact of the EHBs** from existing evaluations and key informant perceptions, including the methods used and findings on the impact of the EHB service performance and in meeting national policy commitments.

The country case studies were undertaken in four ESA countries: Swaziland, Tanzania, Uganda and Zambia. Implemented by teams led by or involving ministry of health officials in those countries, working with other personnel, the country case studies included:

1. Document review and proposals for key informant interviews, with regional peer review.
2. Key informant interviews with current and former government health officials, and health stakeholders from national technical agencies and private health services, from civil society and from international agencies. Fourteen key informants were interviewed in Tanzania and eleven each in Uganda and Zambia. Swaziland carried out only a desk review due to time limitations. The interview findings were integrated in the case study reports, and the report was validated in a one-day national review meeting in Tanzania, Uganda and Zambia, together with regional (IHI and TARSC) and external peer review.

The country case studies have been separately published for Swaziland (Magagula, 2017); Tanzania (Todd et al., 2017); Uganda (Kadowa, 2017); and Zambia (Luwabelwa et al., 2017).

This regional synthesis integrates key findings and learning from across all areas of the work, including the regional desk review and country case studies.

The structure used covered:

- The context for applying EHBs, the terms used for them and their purpose.
- The policy motivations for, and processes and stages of development of the EHBs.
- The methods and processes used in their design and costing, the benefits included and their costs and the limitations and issues in applying the methods.
- The use and implementation of the EHB, how they were disseminated, applied in practice, used in funding services, in strategic purchasing and in monitoring and accountability on service performance; and the issues and challenges faced.
- Evidence of impact of the EHB on health systems.

The evidence was tabulated from a manual thematic analysis of the four country case studies with cross check and further capture of evidence from the regional desk review and country case studies. The findings were presented, reviewed and validated by country and as a regional synthesis in a regional meeting in November 2017, involving representatives of all country authors, TARSC, IHI, ECSA HC and other partners.

2.2 Limitations of the methods

Various limitations are noted in the methods: In the regional literature review, only English language materials were included. Possible loss of evidence in the country case studies due to limitations in what is formally documented and a recall bias in a relatively small sample of key informants was addressed in part by triangulating evidence from the different methods and by holding national validation meetings on the findings. The regional synthesis loses some of the detail in the country reports, but these are published to facilitate access to this greater detail.

3. THE CONTEXT FOR APPLYING AN EHB IN THE REGION

3.1 The socio-economic context

The 16 ESA countries covered had in 2012 a combined population of 343 million, 5% of the global population, with a younger demographic profile than the African and global average (EQUINET 2012). There is a wide variation in their socio-economic status, with a range in per capita gross domestic product (GDP) from $100 to $5,800 (all dollar figures in this report reflect current/ nominal US dollar unless otherwise indicated) (EQUINET, 2012). Income poverty is high in most of the countries in the region. It increased between 1990 and 2010, including in countries where per capita GDP grew, signalling persistent income inequality (EQUINET, 2012). These socio-economic conditions imply that a large share of the population relies on accessing public sector services for their healthcare, and that the costs of accessing healthcare should not lead to further impoverishment.

As shown in *Table 1*, the four case study countries, all lower-middle income countries, also vary in population size and socio-economic status. Despite Swaziland and Zambia having higher levels of per capita GDP, they also have higher shares of people living below the poverty line and wider levels of inequality in wealth than Tanzania and Uganda have (see *Table 1*). All four countries face similar pressures to protect relatively high shares of vulnerable people from impoverishment due to ill health, including through relevant, equitable health systems.

Table 1: Socio-economic indicators, case study countries, 2009-2017

	Administration	Population (million), 2016	Annual GDP growth rate (%), 2016	GDP/ capita $ 2016	% below the national poverty line	Gini index (inequality 0=low 100=highest)
Swaziland	4 regions 55 local authorities	1.34	2.2	2775.2	63.0 (2009)	51.45 (2009)
Tanzania	30 regions 169 districts	55.56	7.0	879.2	28.2 (2016)	37.78 (2011)
Uganda	4 regions 124 districts	41.49	4.0	615.3	19.5 (2012)	42.37 (2012)
Zambia	10 provinces 106 districts	16.59	3.3	1,178.4	54.4 (2015)	55.62 (2010)

Sources: Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017; World Bank, 2017.

3.2 Health and health system features

Table 2a shows the wide range in life expectancy across ESA countries and the inequalities in life expectancy and health outcomes by wealth, rural-urban residence, mothers' education and other social factors (EQUINET, 2012).

In the region, morbidity and mortality generally relate to poor outcomes in nutrition, sexual and reproductive health, HIV, maternal and child health and communicable diseases, albeit with rapidly rising levels of non-communicable diseases. This pattern of morbidity is associated with people's living, working and community conditions and lifestyles, with social differences in exposure to risk and vulnerability to disease (EQUINET, 2012; WHO, 2016). For the health sector, this raises a challenge to promote health in the policies and work of other sectors and to public health and prevention to avoid facing an unmanageable escalation in healthcare costs.

Table 2a: Health system indicators, ESA countries, post-2010

	Life Expectancy (years)	Constitutional Right to Health	Total Health Exp. /capita USD	Health Exp. as % of Total Expenditure	Out-of-pocket exp. as % of Total health expenditure	Density Nurses and Midwives per/10,000	Hospital Beds per/10,000	Pregnant women with at least 4 ANC Visits (%)
Angola	52	◆	148	6.8	19	13.5	8	na
Botswana	61		530	16.6	5	28.4	18	73.3*
Democratic Republic of Congo (DRC)	49	◆	13	17.5	39	5.3	8	48.0
Kenya	60	◆	33	5.8	27	11.8	14	57.6
Lesotho	48		60	8.2	17	6.2	13	74.4
Madagascar	65		22	14.6	31	3.2	3	51.1
Malawi	47	◆	18	12.1	13	2.8	11	44.7
Mauritius	73		402	8.3	47	37.3	33	na
Mozambique	49	◆	21	12.6	7	3.1	8	50.6
Namibia	57		284	12.1	7	27.8	27	62.5
South Africa	54	◆	459	10.4	7	40.8	28	87.1*
Swaziland	49		141	8.5	10	63	21	76.0
Tanzania	55		22	18.0	23	2.4	11	42.8
Uganda	52	◆	44	10.5	39	13.1	4	47.6**
Zambia	48		68	15.3	30	7.1	19	55.5
Zimbabwe	49	◆	79*	8.2	34	7.2	30	70.1

(*) for 2007

(**) key informant reported 30% for this indicator from national health accounts; na= not applicable

Note: The life expectancies are for 2011 as the year for which all country data were available and have changed to current. For example, Uganda life expectancy in 2016 was 63.3 (Kadowa, 2017).

Sources: EQUINET, 2012; MoHCC et al., 2015; TARSC and MoHCC, 2014; WHO, 2011, 2016

By 2015/16, the four case study countries had shown improvements in life expectancy, infant and under-five mortality, but with still relatively high levels of neonatal and maternal mortality (*Table 2b*). As for the rest of the region, the countries are all experiencing a high share of communicable diseases (HIV, tuberculosis and malaria), but also rising levels of chronic conditions, including diabetes, hypertension, injuries and cancers. This double burden of ill health in all ESA countries presents a demand to not only sustain and extend coverage of existing services, but to add new services and reorient approaches to meet new health challenges.

Table 2b: Mortality data, case study countries, 2015-16

	Life expectancy at birth (yrs) 2015/6	Infant mortality/ 1000 live births, 2016	Under-5 mortality rate 2016	Neonatal mortality rate/ 1000 live births 2016	Maternal mortality ratio/ 100 000, 2015
Swaziland	56.9	52	67	21	389
Tanzania	64.9	40	67	22	398
Uganda	63.3	43	64	27	336
Zambia	61.3	44	75	23	224

Sources: World Bank, 2017; Uganda data from 2016 DHS data in Kadowa, 2017.

While seven of the sixteen ESA countries include the right to healthcare within their constitutions and elaborate this further in health laws, of the four case study countries only Uganda includes a provision ensuring basic medical services to the population. In the other three, the state's duty to provide healthcare is expressed in policy and subsidiary laws, rather than as a constitutional right.

Promising trends in the 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 (EQUINET, 2012). At the same time, many countries still face shortfalls in meeting key health and health service goals (EQUINET, 2012).

The promotive, preventive, curative and rehabilitative services in the public sector of the case study countries are provided through an extensive and interacting network of services at community, primary care (health centre/level 1) level, secondary (district/general hospital) level, tertiary (regional/provincial hospital) level and quaternary (national referral hospital) level.

They show some differences in nomenclature and level of decentralisation of authority, as shown in *Appendix 1*, *Table A1*, with:

- *Differences in ministerial roles.* In Tanzania, for example, the Ministry of Health, Community Development, Gender and Children acts as technical adviser and provides policy and governance input and oversight, while the President's Office, Regional and Local Government (PO-RALG), is responsible for implementation through local government authorities (LGAs). In Uganda and Zambia, the Ministry of Health (MoH) is responsible for policy, planning, quality assurance and oversight and in Uganda for national and regional referral hospitals, while local government provides district and primary care services.
- *Differences in community roles:* Tanzania has a policy commitment to involve communities in prioritising and planning local health services, albeit not uniformly implemented. In Uganda and Zambia communities and health workers play these roles through local health committees, with Uganda's health unit management committees appointed by MoH and Zambia's neighbourhood health committees elected by communities.
- *Common mechanisms for co-ordination with other stakeholders* and health sector partners, and some under sector-wide approaches. National MoH management units have varying influence on resources and local service providers for specific health programmes, and sector advisory groups have varying influence on policy and oversight, while outreach and service integration to meet new challenges like chronic conditions is a work in progress in all.

These features of governance, decentralisation and disaggregation into multiple facility levels make it important to clarify what service benefits are provided at different levels.

In all ESA countries, public sector health services are complemented by private, not-for-profit (faith-based and non-government) services and private, for-profit services that provide community, primary, secondary-level care and specialised services, although their relative size and complementarity with public services varies (EQUINET, 2012).

In the case study countries, domestic private expenditure as a share of total current health expenditure ranged in 2015 from 20% in Swaziland and 28% in Uganda to 39% in Zambia and 47% in Uganda (WHO, 2017). These relatively significant shares suggest that an EHB defined on the basis of national health needs should apply in private sector services. The findings explore how far this is realised.

While there is some variation in ESA country health systems, the allocation of funds, health personnel, infrastructure and equipment affect delivery on policy intentions in all. highlights a low density of key health workers in many ESA countries, with many below the WHO recommended minimum of 23 doctors, nurses and midwives per 10,000 population density needed to deliver essential maternal and child health services (less so in Swaziland).

Lower service levels that lack adequate inputs and personnel to fulfil their role may refer patients to more costly higher-level services, and patients who bypass services with deficits do so at higher cost to themselves and the health system. Adequate and equitable financing is thus a key challenge for delivery on national policy goals across the region.

Many ESA countries face shortfalls in health funding, many are making slow progress towards meeting the Abuja commitment of 15% government financing or 5% of GDP funding for healthcare, out-of-pocket spending is high and health financing pools are segmented across programmes and providers (*Table 2a,* EQUINET, 2012).

This is equally the case for the four case study countries, as shown in *Table 2c,* where, for all except Swaziland, the low share of public health spending in the GDP and high dependency on external financing and out-of–pocket spending pose challenges to equity, sustainability and integration of services.

Table 2c: Health financing indicators, 2014

Health expenditures:	Health expenditure per capita, current, US$	Public health expenditure as % THE	Public health expenditure as % GDP	External resources as % THE	OOP expenditure as % THE	OOP expenditure as % private health expenditure
Swaziland	248	75.7	7.0	21.7	10.3	42.4
Tanzania	52	46.4	2.6	35.9	23.2	43.3
Uganda	52	24.9	1.8	na	41.0	54.6
Zambia	86	55.3	2.8	38.4	30.0	67.2

Source: World Bank, 2017; THE = total health expenditure; OOP = out-of-pocket.

In the face of scarce resources, attention has been given to linking resources to performance-based funding for selected maternal and child health services. Shortfalls on budget bids, however, mean that health ministries face a number of difficult choices: How to ration and equitably allocate scarce resources? How to align different funders and providers to ensure widest health benefit? How to ensure that targeted funding for selected services does not negatively affect delivery of other important services? How to build a trajectory to prevent and manage major current disease burdens *and* to avoid future health costs? The case studies provided further evidence on the role that an EHB plays in addressing these choices.

4. DEVELOPMENT OF EHBS IN THE REGION

The contexts described in the previous section raise motivations for and challenges in developing and using an EHB to meet legal duties and population health needs in ways that support policy goals of universality, equity and effective, efficient use of available resources. This section discusses the findings on the experiences within ESA countries.

4.1 Names and purposes of the EHBs in the region

Of the sixteen ESA countries, 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, as shown in *Appendix 2*, *Table A2*. In the four case study countries, the EHB is differently termed:

- In Swaziland, the Essential Health Care Package (EHCP) was set up to enable effective and equitable health service delivery (Magagula, 2017).
- In Tanzania, the National Essential Health Care Intervention Programme (NEHCIP) supports integration of cost-effective interventions that address the main health problems and risks (Todd et al., 2017).
- In Uganda, the Uganda Minimum Health Care Package (UMHCP) focuses on limited resources to support decentralised delivery of cost-effective interventions to meet health needs and services, particularly of women and rural populations (Kadowa, 2017).
- In Zambia, the National Health Care Package (NHCP) was set up to align services with the development plan and strengthen the health system to provide equitable, cost-effective and quality health services (Luwabelwa et al., 2017).

4.2 Policy motivations for development of EHBs

Each of the thirteen ESA countries that were working on or implementing EHBs broadly stated policy intentions in doing so to promote universal access and equity in health, to respond to national priority health burdens and to promote cost-effective interventions (Todd et al., 2016). They were developed to identify the cost of healthcare services to advocate for health funding; to purchase services or to ensure service delivery at system scale; and to clarify and support equitable access to entitlements, to realise rights to healthcare (Todd et al., 2016). Prioritising services for resource planning was a significant driver of the early development of EHBs, particularly after the World Bank 'Investing in Health' report used disability-adjusted life years (DALYs) saved to judge cost effectiveness of different health sector interventions (World Bank, 1993). There was debate, however, over using DALYs to prioritise health services. In Tanzania, for example, a Tanzania Essential Health Intervention Programme (TEHIP) pilot used evidence from the health information system, the essential medicines programme and the Demographic Surveillance Systems for prioritising health needs (De Savigny et al., 2002). In later rights-based approaches, four ESA countries (Kenya, Namibia, South Africa and Zimbabwe) reported developing EHBs to clarify state duties, given inclusion of rights to healthcare in the national constitution (Todd et al., 2016).

The technical focus in most ESA countries perhaps reflects the regional finding that while funder, provider and community stakeholders were involved in discussion of a benefit package based on technical evidence, the more limited, structured direct dialogue for communities to contribute their perceptions of service priorities raised questions on how widely the subsequent EHB is known and 'owned'. In contrast, in Kenya, an innovative community manual on EHBs was used for communities to prioritise the services to include in the EHB, accompanied by a capacity building process (RoK, 2006; Muga et al., 2005). In Zimbabwe, community-based surveys were used to elicit community priorities in the 2013 process for updating the EHB (MoHCC et al., 2015). In both settings, community evidence was combined with national burden of disease assessments.

Table A3 in the Appendix summarises the policy documents and strategic plans between 1960 and 2017 that make specific reference to motivations for developing or reviewing an EHB. They indicate that across the four countries, the EHB was designed:

i. Within the macro-economic restructuring and structural adjustment of the 1990s to more stringently prioritise health interventions in 'evidence-based' planning as a means of rationing and targeting use of falling public resources (Kadowa, 2017).

ii. Within the global momentum for the Millennium Development Goals (MDGs) in the early 2000s, especially MDGs 3, 4 and 5, to focus on increasing coverage and quality of maternal and child health services (Kadowa, 2017).

iii. In line with the 2008 Ouagadougou Declaration on PHC and health systems in Africa, endorsed by all African WHO member states, that recommended that states develop or review EHBs, taking into consideration high priority conditions and high impact interventions, to achieve universal coverage (Magagula, 2017; WHO, 2008).

iv. To clarify in response to national constitutions (as in Swaziland) or policy commitments (in all countries) the entitlements that should be available to all, particularly given global SDG commitments on UHC (Magagula, 2017; Todd et al., 2017).

v. To address limited health sector funding, cost the services for and ensure that the government meets prioritised healthcare needs of the population and to clarify infrastructure, equipment and staffing gaps to deliver these services (Zikusooka et al., 2009; Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017).

vi. To focus resource allocations on services that have greatest cost benefit in reducing morbidity and mortality for prioritised conditions, that are socially, politically and culturally acceptable and affordable (Kadowa, 2017; Luwabelwa et al., 2017; Todd et al., 2017).

vii. To foster co-ordination in planning, budgeting and implementation of services across various providers and in an integrated manner at all levels of the system (GoU, 2016a).

viii. To support decentralisation by ensuring that district local governments are clear about and implement plans to deliver EHB elements to residents in their area (GoU, 2008).

ix. As a poverty reducing measure, to clarify the services that need to be provided to protect against impoverishment due to ill health and healthcare costs and to address poverty as a cause of ill health, including through free at point-of-care services (Kadowa, 2017).

x. To build trust between citizens and state on their respective rights and duties after periods of civil strife and to build public accountability through reporting service performance against defined standards (Kadowa, 2017).

Box 1 below outlines as an example how these motivations combined to inform the development of the EHB in Uganda, with a combination of international and national influences, demands to address equity, universality and entitlements, to respond to public health evidence and to address funding and cost benefit concerns.

BOX 1: Motivations for development of the essential health benefit in Uganda

In Uganda, the motivations for development of the minimum package included:

- *The high burden of disease*, with over 75% of life years found to be lost due to ten preventable diseases, combined with the need to address a marked upsurge in non-communicable diseases.
- *Inability to implement primary healthcare holistically*, after adoption of selective vertical packages for primary care due to difficulties with implementing comprehensive PHC.
- *International conditionality*, set in the 1990s macro-economic restructuring that made access to development financing conditional on more stringent targeting of prioritised health interventions.

- *Limited resources*, with implementation of cost-effective interventions seen to help achieve value for money in applying limited resources to meet a high disease burden.
- *Reduction of poverty*, with approximately 46% of people living in absolute poverty, poverty identified to be a leading cause of poor health and ill health and out-of-pocket payments for health identified as drivers of poverty within the national poverty eradication plans.
- *To address equity*, as a benefit to be made available to all based on need regardless of age, gender or location, guaranteed and funded by the state and without charges at point of care.
- *To overcome the limited coverage and access to health services*, noting gaps in service availability within and between districts and to clarify service and capacity gaps from dilapidated infrastructure, equipment and staffing that compromise efficiency, quality and utilisation.
- *To address political considerations and support accountability* as a tool to hold government, policy makers, healthcare providers and all other players accountable, including to enable oversight from parliament, external funders, local governments and civil society.

Sources: Kadowa, 2017; Ssengooba, 2004.

These motivations reflect a broad menu of concerns. How far the resulting EHB satisfies these motivations, and which are given greater de facto profile, are discussed in subsequent sections.

4.3 Stages in development of the EHBs

By 2016, according to the document review, thirteen countries had designed EHBs; ten had set them in policy; nine had implemented them; and five had evaluated them (*Table 4a*). Fewer were reported to be at the stage of implementation than policy uptake and development. The four country case studies provided a more updated and deeper understanding of the transition from design to implementation and evaluation, however. In each country the benefit package has evolved over time, sometimes with revisions on its name, scale and/ or purpose (See *Table 4b*).

Table 4a: Stage of development of the EHBs in the ESA region

Key: Impl. = Implementation; Eval. = Evaluation; Spe.Loc = Specific Locations

Country	EHB	Stage of EHB				Initiators of EHB		Scale	
		Design	*Policy*	*Impl*	*Eval*	*Govern-ment*	*External Funder*	*National Package*	*Spe. Loc.*
Angola	2006	◆		◆			◆		◆
Botswana	2010	◆	◆	◆		◆	◆	◆	
DRC	2012	◆		◆			◆		◆
Kenya	2005	◆	◆	◆	◆	◆		◆	
Lesotho	2003	◆	◆			◆		◆	
Madagascar	–								
Malawi	1999	◆	◆	◆	◆	◆		◆	
Mauritius	–								
Mozambique	–								
Namibia	2010	◆	◆			◆		◆	
South Africa	1997	◆	◆	◆	◆	◆		◆	
Swaziland	2010	◆	◆			◆		◆	
Tanzania (*)	2000	◆	◆			◆	◆	◆	
Uganda	2010	◆	◆	◆	◆	◆		◆	
Zambia	2015	◆				◆		◆	
Zimbabwe	2014	◆	◆	◆		◆	◆	◆	

(*) Year when the EHB was first initiated/defined/ implemented. Note that follow up case study evidence discussed below points to implementation in Tanzania. (**) = An EHB was piloted in 1996.

Sources: Todd, Mamdani and Loewenson, 2016.

Table 4b: Overview of the development of EHBs over time

	1990-00	2000 -current
Swaziland		2010- 2012 development of the 2012 EHCP 2017, development, piloting of a limited minimum health benefit package (MHBP) in 10 clinics in all 4 regions based on a cost affordable to the country
Tanzania	1999 development of the TEHIP pilot	2000 Development of the national package of essential health 2013 Development of the NEHCIP-TZ
Uganda	1999 UNMHCP developed	2010 UNMHCP revised and updated
Zambia	1993-1996 Paper on Essential Basic Package of Health Care 1997: First formal EHB 1998: 2nd and 3rd level Hospital package added	2000: Basic healthcare package (community to third level), with revisions in in 2003 and 2004 2003 Basic healthcare package (1st, 2nd and 3rd level services) costed but not fully adopted 2009 National Health Care Package developed 2017 Benefit package defined for the Social Health Insurance Scheme under review

Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017, Zambia MoH 2000, 2003, 2006, 2012.

Tanzania was one of the first ESA countries to introduce an EHB in the mid-1990s. The TEHIP, and its analysis of health information system data to prioritise services in district planning, was instrumental in the development of Tanzania's first EHB in 2000, further refined in 2013 in the current National Essential Health Interventions Package (NEHCIP-TZ) within the national health strategy (Todd et al., 2017). The EHB was also embedded within national health strategy processes in Uganda in the 2000s, where the UNMHCP was operationalised within health sector strategic plans (Kadowa, 2017). In Zambia, the EHB was revised and costed in various rounds. While not fully operational, it is feeding into the discussions on health financing and national health insurance (Luwabelwa et al., 2017). In Swaziland, work in 2017 sought to identify those elements in the 2012 EHB that the country could afford to deliver (Magagula, 2017).

It is evident that ESA countries have implemented a significant body of work to identify and update prioritised services, whether on grounds of public health and poverty reduction, as a basis for clarifying and building public accountability on entitlements and service performance, to focus and equitably use scarce resources and to contribute to operationalising and identifying capacity gaps for strategic plans. The next section discusses the structure of these EHBs. At the same time the evidence of a policy implementation gap is further explored in *Section 6*.

5. DESIGN OF THE CURRENT EHBS IN THE REGION

5.1 Methods and processes used to design the EHB

Generally, countries define benefits as positive lists when they are linked to what insurance will *include* in its cover, while in tax-funded systems the benefit package may be more commonly defined as a negative list of what the tax-funded service will *exclude*, based on budget limitations and equity considerations (Waddington, 2013). In the regional document review there is no evidence of a uniform or standardised approach or data sources being used to define or prioritise the benefits and varying ways of integrating health needs and burdens and the views of stakeholders (TARSC, 2012; Todd et al., 2016).

Given the motivations described in *Section 4.2* the design generally includes methods to identify the major disease burdens contributing to morbidity and mortality; to assess the health service interventions that have greatest benefit and value for money/cost effectiveness in preventing and reducing these disease burdens; to assess the resources, systems and management strategies needed to implement these interventions and to integrate the perceptions of key stakeholders on these elements, as exemplified in Tanzania in *Box 2*. The four country case studies provide evidence of useful methods that may be shared within the region, summarised in *Table A5* in *Appendix 2*. The methods for costing the package are discussed later in *Section 6.1*.

Box 2: Widening the lens on health needs and disease burdens for the EHB in Tanzania

Tanzania's national NEHCIP-TZ takes into account national policy commitments and strategies for UHC, equity, accessibility and efficiency in health. It also focuses on prevention and health promotion. Beyond curative care, it prioritises communities, behaviour and the environment, emphasising the health sector role in addressing social determinants of health and in building safe, secure and healthy communities. A shift in thinking away from vertical disease programmes as the primary basis for defining the EHB reflects an understanding of the need for wider health system strengthening beyond specific areas of service provision. System issues are addressed by taking into account the measures to operationalise identified benefits, through clusters of services provided at different levels in public and private sectors, together with strategies to improve staffing, a standard quality of infrastructure, improved financing and strengthened decentralisation, and attention to how the benefit package could include measures to promote intersectoral collaboration.

Source: Todd et al., 2017.

In all four countries, the EHB design was guided by development and health policies, not simply as a 'list' of services but more as an integrated service package backed by protocols and service standards. The process of consultation, expert and stakeholder review and policy review, while diverse in form across the countries, played an important role in all. All countries used data on services and costs – albeit in different ways – and diverse other forms of evidence to assess benefit and value for money. All countries assessed their disease burdens, and identified prevention and care service responses to priority burdens. (See examples of services included in *Appendix A2 Table A4*.) Criteria of equity, cost benefit/value for money/cost effectiveness were commonly applied, as were feasibility criteria of whether capacities existed to deliver the services at each level, assessed against available service guidance. Some countries added further dimensions, including attention to social determinants of health in Tanzania; to interventions that support poverty reduction in Uganda; to long-term benefit for population health, survival and quality of life in Zambia and responsiveness to clients in Swaziland.

The country case studies point to further issues on the design of EHBs:

- Zambia triangulated evidence from other countries in assessing health burdens and interventions, to both address evidence gaps and validate local findings.
- In Swaziland, the EHB is designed as "a dynamic document that evolves together with the needs of the population and its health conditions" (Magugula, 2017, p10). Kadowa (2017) observed that EHBs in Uganda need to be updated periodically in line with the national policy, health and financing context, and with international commitments.
- In Tanzania, the TEHIP pilot and integration of the benefit package into district health and comprehensive council health plans and its use in resource allocation, in service delivery and accountability on service performance, provided useful learning for developing, updating and improving iterations of the EHB over time (Todd et al., 2017).

The EHB was found to serve as a potential tool for holistic approaches, to build the health system within sector-wide approaches, including in interaction with other sectors to address the social determinants of health. In the 2017 regional review meeting, delegates thus raised the need to not only prevent and manage *current* morbidity but to include interventions to manage projected, longer-term health burdens through health promotion and action by other sectors. This was noted to potentially reduce future costs, but also needed to be balanced against what is feasible, given current service demands, capacities and resources. This evidently implies both technical and political decisions.

Countries identified consultative processes as useful for building political, public and other leadership understanding of and support for the EHB, and the development processes were consultative to varying degrees in all four countries. They involved government, non-state, technical and international agencies, primarily from the health sector. They varied in how far other sectors, local health providers and communities were aware of or involved, and not all ended with formal adoption by cabinet and parliament.

5.2 Benefits and service levels included in the EHB

The EHBs in the ESA region have different structures in terms of the benefits included and the social groups covered, most explicitly national packages, largely intended to apply in the public sector and to all service levels (Todd et al., 2016). Many EHBs are broadly stated and comprehensive, covering services for sexual and reproductive health, maternal and child health, communicable and non-communicable diseases and public health, with more limited cover of specialised clinical, surgery and related laboratory services, as shown in *Table 5a*.

In the four case study countries, the EHB evolved over time, covering widening service levels, and defining and prioritising benefits (*Table 5b*), as exemplified in Tanzania's progression from the TEHIP pilot in selected districts to the nationally applied NEHCIP-TZ.

In the public sector, the EHBs in some settings started with primary, secondary and tertiary level, but now all cover all levels of care. In Swaziland, Tanzania and Zambia there is an explicit intention for the EHP to cover private and public sector services, although it is not clear how far this has been achieved.

Table 5a: Categories included as priority in the EHBs in ESA countries, 2016

Country	Service areas included in the EHB						
	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.

Table 5b: Coverage, definition and integration of EHB services, case study countries 1990-2017

	1990-00	2000 -current
Level of care, priority programmes and integrated approach		
Swaziland	No EHB	All levels; priority diseases defined; integrated approach
Tanzania	Primary to quaternary pilot areas; priority programmes defined; integrated approach	All levels nationally; priority diseases defined; integrated approach
Uganda	All levels; priority programmes defined	All levels; integrated approach
Zambia	Primary to tertiary levels; priority programmes defined; integrated approach	All levels; 12 priority diseases; integrated approach

Sources: Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017.

In terms of their content, *Table 5c* overleaf outlines the services and priority programmes included in the most recent EHB in each of the four case study countries, while *Appendix 2, Tables A4a and b* provide examples of the detailed packages in Uganda and Zambia. The EHBs generally cover similar services for communicable and non-communicable diseases, for maternal and child health and for public health interventions, with laboratory, paramedical and allied services.

Table 5c: Content of current EHBs

Services/interventions to address the burden of disease	
Swaziland	2,347 proposed interventions were grouped into four healthcare packages: 1) essential public health services; 2) essential clinical care services; 3) allied health services; and 4) support services. The services covered included services for communicable diseases (HIV, TB, malaria), cancers and other non-communicable diseases, reproductive, maternal, neonatal and child health; neglected tropical diseases; common medical problems, medical specialities, surgical conditions, surgical specialities, paediatrics, dentistry, occupational therapy/physiotherapy, speech and hearing (2016); at levels 2-5 also inclusion of mental health, oral health; and palliative care (2017). A minimum health service package is being considered in 2017, covering management of HIV, tuberculosis, diabetes, hypertension, mother and child health and cancer.
Tanzania	Four service clusters were identified based on the burden of disease, provided at increasing levels of complexity at primary, secondary, tertiary and quaternary levels and including health promotion and disease prevention. The core interventions are included in comprehensive council health plans and use effective referral systems: 1) Reproductive, maternal, neonatal and child health; i.e. sexual and reproductive health, antenatal, delivery, new-born, post-partum and post-abortion care, gender-based violence 2) Communicable: i.e. HIV (testing, prevention of mother-to-child transmission), STI management, male circumcision, nutrition, community-based care, stigma and discrimination reduction 3) Non-communicable: i.e. acute/chronic respiratory diseases, cardiovascular, diabetes, mental health, substance abuse, anaemia, injuries/trauma 4) Neglected tropical diseases: i.e. delivery services for neglected tropical diseases, setting emergency and immediate response plans, food safety, infrastructure and pharmaceutical supplies. The 2013 NEHCIP adds a focus on services for the social determinants of health.
Uganda	Four clusters have been prioritised: 1) Health promotion, disease prevention and community health initiatives, including epidemic and disaster preparedness 2) Maternal and child healthcare 3) Control of communicable diseases 4) Control of non-communicable diseases.
Zambia	Five clusters were identified (2004): 1) Child health and immunisation 2) Maternal healthcare 3) Control of communicable diseases 4) Epidemic preparedness 5) Information, education and communication.

Key: HIV= human immunodeficiency virus: TB= tuberculosis; NEHCIP=National essential health care intervention package.

Sources: Kadowa, 2017; Luwabelwa et al., 2017Magagula, 2017; Todd et al., 2017.

Table 5c reflects the policy intention to address the broad range of major population health needs in the benefit package in all four countries. The next sections explore how countries have implemented and used costing of their EHBs to reconcile policy intentions with the resources available.

6. COSTING THE EHB

6.1 Methods used for costing the EHB

The costing of the benefits provides key evidence to prioritise interventions, to inform decision-making on the service package, identify resource gaps and, as discussed in *Section 7*, to align and negotiate funding. In the regional document review, seven ESA countries (Kenya, Tanzania, Uganda, Malawi, South Africa, Swaziland and Zimbabwe) reported diverse methods for costing their EHBs. It was not always clear what was covered and what assumptions were used.

In the country case studies, various sources of data have been used for the costing, including: data from national accounts; medicine and commodity input costs; person-months worked and average contact time for the service from facility data (Swaziland, Zambia); input costs of medicines, hospital beds; laboratory and office supplies; travel expenses; utility and maintenance; supervision allowances; information, communication and social marketing costs; in-service training; and national management support (Tanzania); and wages and staff time, using population figures to assess per capita costs (in Zambia).

This evidence was used to cost the EHB in different ways across the four countries:

a. Swaziland's EHCP used the cost data to estimate total costs for each of the EHCP services at government health facilities (2010-2012), with resource requirements to provide EHCP benefits projected for the next 3 years (Magagula, 2017; MoH, 2011).
b. Tanzania used the data to estimate the full system costs of its NEHCIP intervention packages, providing a spectrum of estimates by modelling and costing alternatively 'best', 'expected' and 'actual' service delivery scenarios (Todd et al., 2017; URT, 2013).
c. In Uganda, in an 'ingredients approach', the inputs needed to deliver specific interventions were quantified and costed using actual facility costs at different levels of healthcare, validated by providers at each care level, except for central level costs, which were estimated (Kadowa, 2017). Various assumptions were applied: 92% of the total costs were assumed to be recurrent expenditures and 8% capital spending.
d. In Zambia, input costs at each referral level used actual costs in Zambia and some international prices. Cost effectiveness calculations used recurrent rather than capital equipment costs, identifying cost scenarios and estimates based on inputs, and including the potential implications for personnel, infrastructure, equipment, supplies and health financing. provides further detail on the method used in Zambia, as an example from one of the case study countries (Luwabelwa et al., 2017).

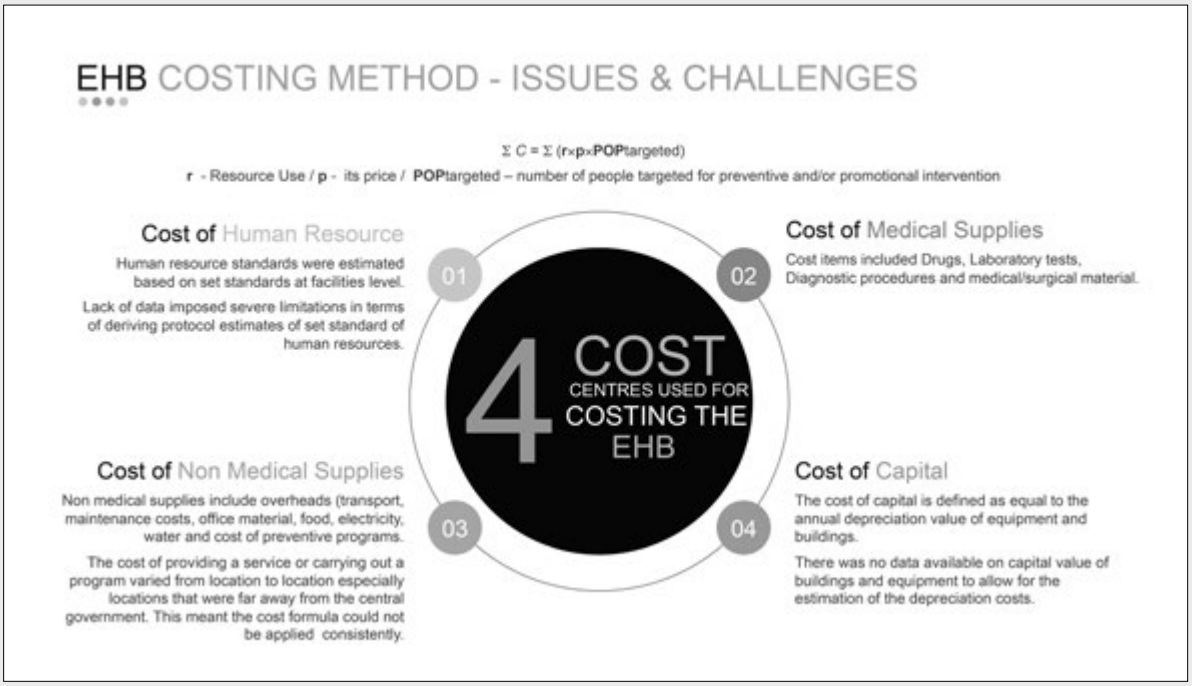
The country case studies cited above identified various limitations in these costing methods:

a. Various assumptions were applied, and while some were documented and can be reviewed, a number were not. For example, difficulties in accessing complete private sector data meant that the costs of services were assumed in Swaziland and Zambia to be the same across public and private health facilities, which may not be the case.
b. The EHB interventions were numerous: In Swaziland, for example, there were 2,400 EHCP interventions, too many to be costed. In such cases service costings were also used from neighbouring Botswana and Lesotho. In Tanzania the large number of services meant that a number of interventions are yet to be fully costed.
c. There was a general assumption in the costing that referral facilities received patients who had been treated at lower level services, which may not be valid.
d. The data used for costings were not always adequate or of good quality, especially in the face of variations in unit costs between districts, levels of care and providers. Assumptions thus had to be made of unit costs, such as in Swaziland. It was not always clear that price adjustments were made for increases in costs over time or what percentage was applied in these adjustments (as for example was done in Zambia). In Uganda the effect of inflation on prices was noted to mean that the costings could become outdated relatively quickly, calling for more regular review, or use of an alternative output and results-based methodology.

e. In Tanzania, the unit costing approach was noted to potentially underestimate the real systems' costs of providing the services, including given the level of vertical and off- budget financing in the system.

Box 3: Costing the EHB in Zambia

In Zambia, the Ministry of Health, the University of Zambia and the Swedish Institute of Health Economics costed the first BHCP in the first, second and third referral levels in the public and private not-for-profit sectors. Detailed and specific costing methods were used, summarised below.



First, the marginal cost of treating one patient with a specific disease according to the treatment protocol was estimated. This was multiplied by the estimated total cases at each level of care in a year. The costs at the district level were calculated using the formula shown in the graphic, where 'r' represents resource use and 'p' its price and POP targeted = the number of people targeted for preventive and/or promotional intervention for the different programme activities. For the total cost of all programme activities in the district, the costs for each programme activity were summed. The costs at all referral levels included the four areas shown in the graphic, and overhead costs were split between district health offices, district hospital and health centres and included materials for maintenance of equipment and structures, office material, transportation costs, food and utility charges, such as for electricity, water and telephones.

The non-medical resources and general overheads for second and third referral levels were based on projections of the number of bed-days at these levels, to calculate overheads per bed-day. To allocate equipment costs, the number of medical doctors at each district hospital was multiplied by the equipment value per doctor. The buildings' values were captured from the infrastructure unit within the Ministry of Health while the capital cost was defined in terms of the annual depreciation value of equipment and buildings, using a simple linear depreciation model. Maintenance costs were captured from MoH estimates of district budgets and included overhead costs. Personnel requirements were estimated based on standards at the facility level, and the average number of minutes a health provider would devote to a patient daily was weighted by the out/inpatient fractions, using health information systems data, and annualised.

A 15% increase in costs was applied as an adjustment to reflect an increase in volume and in prices.

Source: CboH, 2004; Luwabelwa et al., 2017; graphic © Palale 2017.

These limitations do not constitute a basis for not doing the costing work, but they do imply a need to be transparent, document and share information on methods, assumptions, and limitations in setting EHB costs, within countries and regionally. Various approaches were applied that could be used more widely to enhance validity of the costings, including: peer review of cost assumptions and calculations; providing information on assumptions used and guidelines on the methods; and comparing with costings across neighbouring countries.

It was suggested that costing reviews be done or updated every five years, aligned to strategic plans (Kadowa, (2017) and that a national committee be responsible for defining, costing and updating the EHB, to bring in the expertise from the various health sector institutions (Luwabelwa et al., 2017). The potential role for regional exchange, guidance and data to support national costing work is discussed in a later section. It was further evident that while many countries were able to get some data on the private, not-for-profit sector, significant data gaps existed in off-budget expenditures and private-for-profit costs, weakening assessment of costs for national application of the EHB in all sectors, including through private financing/ insurance arrangements.

6.2 Costs estimates for the EHB across the region

For those ESA countries reporting their EHB costing in public domain documents, the costs found in the regional desk review within the wide time range shown in *Table 6a* varied from $4-$25/capita for first-level services to $22-$74/capita for all services.

Table 6a: EHB Cost estimates for selected ESA countries, 1998-2015

Country	EHB Cost	
	Estimated per capita cost in US$ using exchange rates for that year	Year
Kenya	$13/capital for KEPH	2011
Malawi	$22/capita for EHP healthcare across levels	2004
	$28/capita for EHP healthcare	2007/8
South Africa	$31/capita	1998
	$111-$272/capita	2003
Tanzania	$4-$64/capita for benefit package across levels	2015
Uganda	$28/capita for MHCP	2004
Zimbabwe	$16-$25/capita for primary care; $40-$74 for district hospital services	2014

Source: Todd, Mamdani and Loewenson 2016.

The country case study costings are shown in Table 6b overleaf. There is a wide variation across the four case study countries in per capita $ costs at each level and in total, partly reflecting the methods used, and possibly differences in models of care. In Swaziland, for example, the total cost of $519/capita includes the full capital costs of refurbishing all facilities and equipment. In Zambia, this capital cost is applied as a proportional share for the included interventions, discounted annually. Such differences in method result in wide differences in the final costings.

In Tanzania, efforts were made to cost the benefit package in the private, not-for-profit and for-profit sectors. They found differences between these private and public sector costs shown in Table 6b, with per capita US dollar costs as below:

- Private, not for profit: primary $82.08; secondary $130.28; tertiary not available
- Private, for profit: primary $12.61; secondary $277.16; tertiary not available

Table 6b. Estimated US$ cost per capita for EHBs (public sector), most recent data

Service level	ZAMBIA		UGANDA		TANZANIA		SWAZILAND	
	US$/ capita	Year	US$/ capita	Year	US$/ capita	Year	US$/ capita	Year
Primary (community and first level/health centres)	17.59	2003	21.0	2012	83.31	2013	43.00	2013
District hospital services	7.45	2001	7.53	2012	113.24	2013	Na/	
Provincial/regional referral hospital and services	1.47	2003	4.09	2012	130.18	2013	27.00	2013
Central hospital	na	2003	7.29	2012	na	2013	53.00	2013
Total (including MoH and ancillary)	37.70(*)	2003	47.90	2012	na	2013	519.00	2013

All $ figures in USA dollars based on conversion using exchange rate at year of costing; N/A=not available. (*) including HIV interventions, without these it would be $22.70

Sources: Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017

As noted earlier, making comparisons across sectors and countries is difficult given the limitations of the data and methods. However, in all 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. In Tanzania, for example, a 'minimum benefit package' subset of benefits was costed at between $75 and $148 per capita, still yielding a resource gap of between $9mn and $178mn on the state budget (Todd et al., 2017). Similarly in Swaziland a more limited minimum package was costed at $90 per capita, a figure that is within the government budget of $163/capita in 2016/7 (Magagula, 2017).

This whittling down of the EHB to make it affordable for the public sector budget may compromise some of the motivations to provide universal services based on major public health priorities and need, and the discussions it has triggered in country are further explored in the next section.

7. USE AND IMPLEMENTATION OF THE EHB

7.1 Information dissemination on the benefit package

Inclusion of stakeholders in the development of the EHB is one way of ensuring ownership and dissemination. Dissemination of the benefit package has also been managed in guidelines to decentralised district and local government authorities and to promote accountability on service performance (Neilson and Smutylo, 2004). As this area was not well documented in the regional literature, the country case studies provided an opportunity to explore more deeply how the EHB was disseminated. *Table 7a* below shows methods used in the country to formally disseminate and discuss the EHB.

The table indicates a mix of public information outreach, service guidance and review forums for service personnel, consultative policy meetings for policy makers and technical workshops. In Uganda the EHB is also disseminated electronically to government and non-state stakeholders. Specific MoH units were mandated to disseminate the EHB, such as the Quality Assurance Unit in Swaziland, often within wider roles to monitor service performance and provide service guidance. Dissemination was thus often embedded within other processes.

For example, in Uganda, "embedding the minimum package in key policy and strategic documents that are officially launched, published and shared with key stakeholders including other line ministries, local governments, district local authorities and all health providers among others has been an important mechanism of dissemination" (Kadowa, 2017, pps 14-15). In some countries, such as Zambia, involving stakeholders in the design provided a useful means of dissemination. At the same time, there were concerns on the level of awareness of the EHB contents, especially at local service and community level (Luwabelwa et al., 2017; Todd et al., 2017). A clear communication strategy was identified in Tanzania and Zambia to be necessary to avoid misconceptions about how the EHB is understood. While stakeholders were not clear about its contents, they did, however, generally understand its purpose to set a basic standard of healthcare provision that could be accessed without discrimination, and some went further to indicate it as a set of services where access is "…guaranteed to all the population at a cost the public health system can afford" (Luwabelwa et al., 2017, p16).

Table 7a: EHB dissemination strategies, case study countries

	Strategy and forums used
Swaziland	Regional and national campaigns; public dissemination of EHCP in forums, among senior leadership of MoH; road shows, billboards, brochures distributed to the public
Tanzania	Integration in policies communicated to LGAs, albeit with some concern that the detail disseminated may be more limited
Uganda	EHB embedded in policy and strategic documents and disseminated through joint review mission workshops/national health assemblies, annual and quarterly reports, inter-ministerial meetings and electronically
Zambia	Information on the EHB taken to monthly consultative meetings by policy makers to discuss rate setting and provider payment reform. Purchasers (insurers, employers, MoH) organise biannual meetings to discuss summary results and potential implications for their purchasing practices. Analysts and technical peer reviewers meet to discuss detailed costings and potential limitations. Provider associations set up biannual workshops for facility-specific results benchmarked against peer facilities, highlighting cost drivers and potential areas for improving management and performance. Civil society and community members receive summary reports and participate in meetings.

Sources: Magagula, 2017; Todd et al., 2017; Kadowa, 2017; Luwabelwa et al., 2017.

As a measure that is embedded within the functioning of the system, it would thus appear that the EHB becomes known when used as a decision-making tool to strengthen public health management and purchasing of services, to optimise and rationalise resource allocation; and to monitor service delivery. The extent to which this is happening is discussed in the next sections.

7.2 Applying the EHB in practice

While many ESA countries have both a policy intention to have an EHB and have designed their EHB, evidence of implementation is more limited, and a more limited selection of services within the EHB have sometimes been implemented. The experiences of and demands in implementation were explored further in the country case studies.

Swaziland and Zambia are not yet implementing the EHBs. In Swaziland, this is due to the significant costs of the EHCP, thus a more limited initial benefit package is being discussed. At the same time, stakeholder input in development of Swaziland's 2010 EHCP did lead to a number of guidelines relating to treatment and essential medicines: quality assurance; task shifting; referrals and linkages; service availability; primary care infrastructure; staffing norms and supervision. In Zambia the EHB has been aligned with the Sixth National Development Plan (Luwabelwa et al., 2017; Magagula, 2017).

EHB implementation has taken place in Tanzania and Uganda. In Tanzania, the NEHCIP has been incorporated into the national health policy and linked to planning in LGAs and comprehensive health council plans, both processes seen as important to facilitate its implementation. It has been integrated into guidelines for quality standards for health facilities and service delivery budgets, linking it to resource allocation and strategic purchasing. This demands financial resources and personnel, capacity building and management support and governance and management systems to support it (Todd et al., 2017). In Uganda, the UNMHCP has been used to set service priorities in the National Development Plan and for health sector planning, budgets and resource allocation. It has been used in negotiations on financing with the treasury and key development partners (GoU, 2015). It has guided staff establishments and placements, negotiations for wage support and recruitment of critical service personnel, government resource allocation to districts and policy dialogue on the benefit package for the national health insurance scheme and results-based financing. It guides district health management teams in developing strategic and operational plans and budgets within the Mid-term Expenditure Framework (MTEF) and has been helpful in structuring discussions and resource allocation in the health sector-wide approach (GoU, 2015). It has been used to develop guidelines for specific programmes, such as the national TB and malaria control strategic plans; treatment guidelines for common conditions; and inputs to policies such as the National Health Laboratory policy. Key health sector performance indicators used to monitor health sector performance take UNMHCP elements into account (Kadowa, 2017).

While these experiences indicate the various ways the EHBs have been used, a range of implementation challenges have also been reported in these country experiences, including:

- A growing burden of disease, raising demands on services (Swaziland).
- Health service constraints, particularly in terms of inadequate personnel, equipment and infrastructure for the EHB services (Swaziland, Tanzania, Uganda, Zambia).
- Communication and management gaps in moving from the EHB on paper to its application in practice and being clear or giving suitable guidance, supervision and protocols about how implementation should be done (Tanzania, Zambia).
- A 'wish list' of services that does not match what available resources can provide, raising dilemmas for health providers (Tanzania, Swaziland).
- Vertical management and inadequate integration of some EHB services (Uganda).
- Economic challenges reducing MoH revenue to fund the EHB (Swaziland, Uganda).
- Limited, fragmented and unpredictable funding, including from external funders, against the higher costs of implementing the full EHB (Swaziland, Tanzania, Uganda, Zambia).
- Fiscal decentralisation limiting health sector vs other sector budgets at local level (Uganda).
- Poorly functioning and demotivated community-level structures (Zambia).
- Inadequate political buy-in at all levels by parliamentarians, senior MoH management, civil society, private and public sectors and the population at large.

Box 4 summarises the facilitators and barriers found, for example, in Tanzania.

Box 4: Facilitators and barriers of the NEHCIP-TZ in Tanzania

	Facilitators	Barriers
Design	• Evolved over time, built through reviews and consultations • Interconnected with key health policies/ strategy/ vision/standards or quality • Design used a health systems perspective • Used strong health information systems and contributes to monitoring	• Keeping up with the evolving burden of disease • Limited specific programme benefits: defining costs and implementation procedures (e.g., national essential health sector HIV/AIDS intervention package) • Large vulnerable groups to be served • Sustainability concern with limited investment in tertiary levels
Finance	• Positive outcomes where EHB receives additional government funding, such as for vaccines • Shift towards direct facility financing • Development of Health Financing Strategy integrating the EHB to be provided to all citizens	• Inaccurate costing, not using a health system approach, albeit a positive start • Resource gap; funding not reaching districts/facilities • High levels of external funding not always supporting systems improvements (e.g., data, management) • Health Financing Strategy yet to be approved
Use	• Integrated into health planning, expenditure reporting and resource allocation • Councils and district levels central to implementation • Formal platforms to enable collaboration between government and external funders	• Communication gap in dissemination. Lack of clarity on private/public provisioning; provider vs purchaser role • Limited funding for essential management, infrastructure and personnel • In planning process, centralised power and inefficient elements in decentralisation

Source: Todd et al., 2017.

Implementation challenges prevail in all four countries, as exemplified in Box 4 for Tanzania, arising from constraints in the political economy, social, health system, management, communication, financing and resources. At the same time, the EHB is regarded as a tool to 'correct' some of these barriers, to profile the cost and capacity needs to deliver integrated services for UHC that respond to priority health needs, and that align different national providers and funders around these needs and goals. This raises the question of how to deal with the constraints without losing these policy intentions.

7.3 Use of the EHB in funding services and strategic purchasing

With funding a major issue for EHBs, evidence from the regional literature on ESA countries indicate a mix of strategies to fund it, primarily based on tax revenue. Countries also apply external funding to their EHB through sector-wide approaches or system funds (Todd et al., 2016). In Malawi and Botswana, the EHB was stated to be free at point of care, in Zimbabwe this is indicated in policy for primary care level, while some countries indicate this for specific services (Ssengooba, 2004; TARSC and MoHCC, 2014). The country case studies all indicated that while the EHB provides a means to guide health sector financing, all faced a funding gap. Further, while the EHB is a tool for strategic purchasing, its use for this is still limited.

In Swaziland, the EHB has been referred to in discussions on the health financing strategy, and in directing capital investment towards areas of highest need to deliver the benefit package. Magagula (2017) notes that "… government has mobilised funding to facilitate the refurbishment of health infrastructure and systems, to improve efficiency ... to get more value for money and to provide the EHCP" (p20). As noted earlier, the high costs of this capital investment have led to follow-up work to streamline the current benefit package to be more in line with available resources.

In Tanzania, using the EHB in purchasing was seen to require funding of 'facility pre-requisites' that need to be available for delivery of the EHB, such as core health workers, commodities and infrastructure to implement the services, given a wide inequality noted in access to these capacities between urban and rural areas and between districts (Todd et al., 2017). Tanzania's NEHCIP has thus been used as tool for guiding, organising and planning service delivery and for standardising the services provided. Its use in health financing, strategic purchasing and resource allocation is through its integration in planning and budgeting processes at district level, with tools for budgeting and planning at the LGA level to guide priority setting, planning and setting of budgets. While well integrated in the planning and resource allocation process, the NECHIP has yet to be used effectively for strategic purchasing and for resourcing above district level. Tanzania is now preparing for funding from a Direct Financing Facility, in which all facilities will have functional bank accounts and manage and account for their resources. While this may not overcome EHB funding gaps, it may facilitate resource flows to facilities (Todd et al., 2017).

In Uganda, primary healthcare (PHC) services in the EHB are considered for poverty alleviation funding, with these funds ring fenced and protected from budget cuts within the sector. All the programmes in the UNMHCP hold vote functions under which financial resources are appropriated using government funds. There is no means of pooled funding for the EHB, so that resources from other funders are fragmented, without mechanisms for income and risk cross subsidies. The government purchases health services from private, not-for-profit services through grants for specified services based on a memorandum of understanding that covers UNMHCP elements (GoU, 2016b). Health facilities are required to report on the performance of selected key indicators of UNMHCP components as a basis for resource allocation to districts and facilities, and performance contracts have been introduced in referral hospitals whereby personnel are evaluated by key outputs in the UNMHCP (Kadowa, 2017). While Uganda's UNMHCP has played a role in determining the allocation of public funds to health, staffing and other essential inputs, it has not been used successfully to negotiate an increase in the budget, limiting its role in strategic purchasing. It has, however, been useful in prioritizing allocation of the available resources, including in sector-wide funding from external partners (GoU, 2015; Kadowa, 2017). At the same time, it has had a more limited role in aligning other sectors and actors to contribute to health and universal health coverage, such as through intersectoral co-ordination and 'health in all policies'.

Zambia's NHCP reportedly guides planners and clinical staff in purchasing medicines and strengthening infrastructure. Government and not-for-profit services receive tax funding through a resource allocation formula that integrates equity by taking population, deprivation, health needs and service provision into account. The allocation criteria has been under review in recent years, with a view to linking it to the EHB, taking into account the workload and the unit costs of providing different types of services. There is also discussion on the use of the EHB in performance contracts and work on proposals for a social health insurance scheme also make reference to the EHB in discussions on the benefit package (Luwabelwa et al., 2017).

In the case study countries there has thus been discussion on mobilising new resources through national or social health insurance, although, as noted above, this has not always been closely aligned to the current EHB. Unless these insurance funds are pooled with other tax funds to provide a large enough pool to secure the income and risk cross subsidies to fund the EHB for all, there is a risk that they further segment health funding for a specific subgroup, like formal sector workers. In addition there is a still under-explored issue, under debate in some countries, of how the private and public sectors interact and jointly contribute to the common EHB.

In other countries, such as Tanzania and Swaziland, a more limited package is being explored that could be funded with available public resources, as outlined for Swaziland, for example, in *Box 5*. The implications of this for universal health systems are discussed in a later section.

Box 5: Meeting the funding gap in Swaziland

In Swaziland, the funding gap to deliver the EHCP led to discussion of options to streamline it by identifying the most urgent priority interventions that could feasibly be funded. Drawing on a study conducted on the implementation of EHCP on 17 healthcare facilities, a more restricted package was costed as a subset of the EHCP, to include the most essential interventions. Cost estimates were produced for service delivery for those more limited interventions that contribute significantly to the burden of disease that should be accessible to the population at no cost. The cost of this package was significantly less than that of the EHCP: In 2012 when the EHCP cost $106mn, the 'minimum package' cost $58.8mn at a per capita cost of $90. This package is now being piloted. Government appointed a technical working group to assess the existing gaps taking a view of implementation of EHCP in phases. Ten clinic facilities were identified as pilot centres in the four regions of the country, based on the extent of activity levels in each facility. A total of six disease conditions were considered, namely: HIV, TB, hypertension, diabetes, maternal and child health and cervical cancer. The following gaps were identified in service readiness: a shortage of basic equipment and some medicines in the clinics; skills shortages in screening for cervical cancer, and an absence of clinic management of non-communicable diseases such as diabetes and hypertension. Having identified the existing gaps at the clinics, the MoH, in collaboration with development partners (CHAI and PEPFAR), designed a programme of action in which equipment was procured and distributed to the ten clinics. Further, nurses were trained on cervical cancer screening and medicines for managing diabetes and hypertension were made available.

Source: Magagula, 2017

The gap between the EHB intention as a basic entitlement and the reality of limitations in available government financing, unpredictable external funding and a high burden of out-of-pocket financing has thus generated a range of responses in ESA countries. Some countries in the region (such as Uganda, Zambia, DRC and Zimbabwe) have explored new revenue sources from innovative financing (earmarked taxes) and social/national health insurance, motivating international funder and ministry of finance support for adding and pooling resources through cost-benefit and equity analysis of the EHB interventions (Pearson, 2010). In Botswana, in response to an estimated gap of $4.6 million needed to finance its EHB over the five-year period 2013-2018, the country also explored increasing revenue collection through user fees from non-EHSP services and working with willing private insurers to better direct resources to EHB services (GoB, 2010). Others, as noted in Uganda, have explored re-prioritising resources to ensure delivery in primary and secondary level services (Ssengooba, 2004). Others, as noted in Swaziland, have reviewed the EHB to prioritise the most important services to fund, allied with purchasing strategies through contracting, performance financing and resource allocation strategies (Todd et al., 2016). The policy implications of these different approaches and how they address efforts to build equitable universal health systems are further discussed in *Section 9*.

7.4 Use of the EHB in monitoring and accountability on service performance

While there has been significant effort in setting EHBs, the fact that implementation has been more limited also means more limited monitoring and reporting on implementation. In the regional review, only five countries (Uganda, Malawi, Kenya, Tanzania, and South Africa) reported specific measures to evaluate their EHBs in terms of their impact on service delivery, use and resourcing, and to a lesser extent on social accountability and referral systems (Todd et al., 2016). At the same time, ESA countries are strengthening and using their routine health information systems to report on service coverage and performance, including to wider stakeholders. Implicitly such reporting is a form, in part, of monitoring of their EHB, while the definition, purchasing and monitoring of services in the EHB itself potentially motivates investment in health information systems.

As shown in *Table 7b* the four case study countries monitor service performance more broadly through systems that are relevant for monitoring the EHB. The basis for monitoring the EHB thus exists in three of the four countries, largely within current ministry of health monitoring processes and using health information system data, various facility assessments and household surveys.

Table 7b: Monitoring mechanisms established in the health sector

	Mechanism	Purpose
Swaziland	Monitoring and Evaluation Unit Technical working group for EHCP. Features identified for monitoring the EHCP include: access, quality of care, health outputs and health outcomes. The quality assurance unit, in collaboration with the strategic information department, is positioned to take a leadership role in ensuring monitoring and evaluation of the EHCP are implemented. Quarterly and annual reporting systems in place.	Tracks progress and outcomes. Use reporting and feedback from community level, health centres, regional referral hospitals and national referral hospitals in quarterly and annual performance reports of the MoH presented to the House of Parliament and Senate. Some information gaps need to be addressed. The TWG for the EHCP is assessing findings from 10 clinic facilities in 4 regions on capacities and performance in delivering services for 6 diseases to address management and capacity gaps and as input to the financial feasibility of introducing social health insurance.
Tanzania	Quality Assurance Unit in MoHGCDEC, with reporting conducted from the health facility, LGA, districts, regions and ministry. Health data systems through the adult mortality and morbidity project, health management information system, accounting data. Assessments conducted of service availability and readiness (Big Results Now Star Rating; World Bank service delivery indicators) and mid-term review and joint annual health sector performance assessments.	A star-rating tool designed by the quality assurance unit has been used to assess the readiness of primary level facilities to provide quality essential health services. Services failing to meet the minimum standards have been identified for additional support. This is complemented by information from other periodic facility assessments. Available data from the health information system shows progress made in delivering services in the EHB as well as evidence on areas of high expenditure and disease burden, informing assessments of need and prioritisation for district planning. Mid-term and joint annual health sector reviews report on periodic performance of the health sector.
Uganda	Government responsible with partner contributions through programmes and for monitoring and evaluation. Ministry of health conducts quarterly and annual performance reports, with mid-term reviews of the health sector strategic plan and programmes. Mobile phones are used to gain client feedback. Mandatory maternal and perinatal death reviews yield maternal and child health performance indicators, published in the public domain. The Uganda Bureau of Statistics provides further health data.	Monitoring indicators are taken from EHB services to monitor sector performance, through National Service Delivery Surveys to assess progress. The Joint Budget Support Framework (co-ordinated by the Prime Minister's office, government and development partners use these indicators to monitor progress in the health sector. See *Box 6* The UNMHCP monitoring system has been influential in defining minimum standards for service delivery and in closure of stand-alone TB and leprosy services. UBS conducts periodic surveys providing evidence on health needs and on impact and coverage indicators, and service delivery.
Zambia	Monitoring system for the EHB not in place	Because the recent EHB has not been costed and institutionalised, its use in monitoring performance has been limited. However, it sets standards for performance assessment and defines remedial actions to be taken in case of variance from the EHB.

Sources: Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017.

In Uganda, the UNMHCP is used more directly to set indicators for performance monitoring (see *Box 6*). The findings are discussed in various forums and working groups. Tanzania monitors system features relevant for the EHB, such as service performance and quality, through the district health management information system, sample vital registration and verbal autopsy, and the TEHIP and Plan-Rep database on adult morbidity and mortality. Further improvements in monitoring and evaluation systems are being planned in Tanzania with a proposed rollout of LGA Score Cards on service readiness for key areas of delivery, following a star-rating assessment of facilities that found that most facilities are not adequately equipped to provide an acceptable quality of care for EHB services (URT, 2017).

Box 6: Monitoring the EHB in Uganda

In Uganda, the indicators derived from the EHB programmes are used to monitor health sector performance. For instance, the National Service Delivery surveys in 2004, 2008 and 2014 that assess overall government performance use these indicators. Under the joint budget support framework co-ordinated by the office of the Prime Minister, government and key external funders agreed on a joint assessment framework with indicators to monitor progress on set targets. As part of the budget support framework's accountability process, specific health indicators aligned with the UNMHCP, such as immunisation coverage, are monitored and regularly reported on, including impact indicators like maternal mortality, infant mortality and under-five mortality. The Uganda Bureau of Statistics also does periodic surveys for impact and coverage indicators and service delivery assessments. The Ministry of Health conducts quarterly and annual performance reviews of its programmes and departments by assessing achievements of key indicators as set out in the workplan. Mid-term review of the overall sector strategic plan and programme plans analyses progress and recommends remedial actions. The published progress reports are shared widely, including with oversight agencies such as parliament. As part of its oversight function, the parliamentary committee on health closely scrutinises health sector performance. Furthermore, mandatory maternal and perinatal death reviews are conducted as part of accountability for women's and children's health, and the reports are discussed at the ministry of health for follow up. In addition, mTrac, a mobile phone system, is a mechanism for client feedback/redress under an anonymous complaints hotline, toll-free number. People may call or SMS to express opinions about health service-related issues such as good services, closed health centres during working hours and stockout of essential supplies. The same mechanism delivers information about services in the community and feedback on developmental issues, improving accountability on service delivery.

Sources: Kadowa, 2017

The country case studies indicate a need for a monitoring system that generates evidence to support strategic purchasing, performance review and input to a five-yearly revision of the EHB within strategic plans. However, there have been challenges in monitoring due to the adequacy, accuracy, reliability and quality of data, and the limited resources these data platforms receive. Monitoring the wider EHB and the strategic purchasing associated with it has, to some extent, been overshadowed by more focused and limited monitoring of specific services funded by external agencies or, in some countries, through performance-based financing, with monitoring linked to disbursements. This has raised questions on how to include wider system monitoring.

There is also still limited evidence of monitoring being used to support the role of the EHB as a policy intervention that publicly demonstrates fair process and social accountability on services, including rights to services (Waddington, 2013). While some ESA countries use patient or service charters for social accountability on service provision, these do not include public information on what services communities may expect to find at each level. While evidence from service monitoring is reported to funding partners and officials, beyond Uganda's reporting to parliament, evidence from service monitoring being reported to communities or the public for social accountability is limited.

8. IMPACT OF THE EHB ON HEALTH SYSTEMS

Specific evaluation of the application of EHBs in ESA countries has been limited. In the regional analysis, the few evaluations carried out identified potential impacts, outlined in *Table 8* below. The countries that implemented evaluations found evidence of the implementation gap raised earlier, but also noted various impacts where EHB pilots or national level implementation had been effected, including:

- *As positive outcomes:* increased provision and uptake of health services, including in lower income groups (in Malawi, Bowie and Mwase, 2011); improved medicine distribution to dispensaries, reduced response time to treatment and improved communication (in Tanzania, Neilson and Smutylo, 2004); and improved cost effectiveness of services (in Malawi, Bowie and Mwase, 2011).
- *As negative outcomes:* continuing inequalities in services and funding levels between private and public sectors and in access to schemes and services by low-income groups (in South Africa, McIntyre et al., 2003); and concern over how cost escalation is managed, especially in application in the private sector (in South Africa, Taylor et al., 2007).

Table 8: Potential direct and indirect impacts of EHBs in ESA countries

Direct Impact/Outcome	Indirect Impact/Outcome
• Health outcomes • Delivery to vulnerable groups • Health system changes: financing, information, service delivery, policy, supplies, etc. • Equity and equality and universal coverage	• Impact across public sectors i.e. education, water, planning etc. • Impact on structure of government • Impact on private sector (services and financing)

In Swaziland and Zambia, limited implementation meant that it was not possible to assess impact. In Tanzania, where measures have been taken to institutionalise the EHB, the indicators show progress in addressing certain programmes, such as immunisation and some changes in disease burdens, although it is difficult to attribute these changes directly to the EHB. In Uganda, where the EHB has been in place for 17 years, there has been a greater opportunity to monitor impact, while equally noting that many factors moderate any direct causal links between the EHB and these outcomes (see *Box 7* below).

The findings suggest that it would be feasible to gather evidence on how the EHB is associated with changes in service availability, performance and outcomes, disaggregated by level and area through routine health information systems complemented by facility surveys. It would also be important to assess, through existing household surveys and disaggregated by income group, the role the EHB has played in financial protection and poverty reduction.

Box 7: Impact of the EHB in Uganda

During implementation of the UNMHCP in Uganda, the health sector registered marked progress. The improvements may, in part, be attributable to targeted interventions of the UNMHCP elements based on the health indicators that showed improvement in the last decade:

- An annual 5.1% reduction in the maternal mortality ratio in the past ten years and a decline in maternal mortality from 438/100,000 in 2011 to 336/100,000 live births in 2016;
- A decline in the under-five mortality rates from 128/1,000 live births in 2006 to 90/1,000 live births to 64/1,000 live births in 2016; and
- A fall in infant mortality from 71/1,000 live births in 2006 to 43 /1,000 in 2016.
- Despite these mortality reductions, the disease pattern has not changed significantly from that prevailing when the UNMHCP was first introduced, and the benefit package does not address the broader social determinants of health that contribute to health outcomes.

Source: Kadowa, 2017.

9. DISCUSSION

In the 2017 regional meeting, countries raised various features of their EHBs that they found to be good practice, including, collectively: consultative processes in the design that build consensus and support of relevant expertise, implementers, parliamentarians and, in some cases, the public; methods and processes for comprehensive design and updating of benefits and costings, used as a basis for estimating capacity and financing gaps; a systems approach for prioritisation of EHB services linked to health strategic plans; mobilisation of innovative financing and resources from non-state actors; and ring-fenced funding of EHB elements, with equity integrated in resource allocation.

They also raised challenges faced, as outlined in earlier sections, including, collectively: the breadth and number of EHB interventions versus available resources and capacities; financing constraints in meeting the capacities, capital and recurrent costs needed to implement the EHB and gaps in health information system data and in-country expertise for EHB design and monitoring, including from off-budget spending and the private sector. They noted that the EHB should not simply focus on the availability of the services, but also their quality and access to them, often more complex to manage in decentralised services. Challenges were noted in building political understanding and support for the EHB and in using it to leverage the involvement of other sectors affecting health and inclusion of their role in addressing health determinants. This section discusses positive features and challenges as raised in the findings,

9.1 Policy motivations for EHBs: what role in UHC and health equity?

The motivations for designing and implementing EHBs in ESA countries speak to different policy agendas that may sometimes appear to be contradictory.

In line with UHC and health equity agendas, countries are setting EHBs to reflect policy intentions to ensure that the entire population has access to promotive, preventive, curative and rehabilitative health services of a sufficient quality to close avoidable inequalities in health, to guide the allocation of resources and purchasing of health services and the roles of health and other sectors to address health needs and health determinants and to protect against impoverishment from the costs of using health services. This implies extending services to cover everyone, especially those with greatest health need; increasing the range of services to manage major public health burdens; and ensuring that costs of services do not impoverish people, shifting from charges at point of care to prepayments that are made according to income.

This is not a short-term agenda: Universal systems are built over years, organised around a shared vision of a national unified health system. This positions the EHB as a ‘universal health benefit’, clarifying and progressively realising over time constitutional or policy entitlements to healthcare and reflecting global and regional commitments. The EHB plays a role in fostering co-ordination in planning, budgeting, implementing and being accountable for this policy goal and the services it implies across various providers and levels, including identifying the gaps to delivering it. It has also positioned the EHB as a poverty reducing measure, clarifying the services to be provided to protect against impoverishment due to ill health and health care costs. In fulfilling these roles, the EHB thus is seen to have a potential to build communication and trust between citizens and state on their respective rights and duties.

However, there are tensions between this vision and competing policy drivers for financial austerity, economic efficiency (vs public health efficiency) that would lead to current and acute needs being prioritised over longer-term health needs and treatment of disease over promotion and prevention. When introduced within structural adjustment programmes, EHBs were used to stringently prioritise health interventions as both an argument for and a consequence of reduced public sector health funding; using evidence to ration and target use of scarce resources on the basis of their impact on disability adjusted life years lost, including through vertical programmes. With the persistent underfunding of public sector health services in the past decades often below the 2001 Abuja commitment or the 5% GDP needed for UHC, ministries of health have faced persistent pressure for such rationing, while services have allowed a level of informal charges,

weakening coverage and financial protection. A focus on costs and rationing as a driver of EHB design has also made states more cautious about engaging with communities on an EHB, lest it raise expectations on the priorities they identify that cannot be delivered.

As noted in the Zambia case study:

> *The context in which a particular EHB is being discussed can be aspirational, to describe what an intended EHB should eventually look like. It can also be a short-term planning tool, linked more directly to cost and affordability. An aspirational EHB is not fixed, but is something the country continues to invest in by expanding services towards achieving it. Aspirational EHBs have political ramifications. Citizens may be oblivious to it being aspirational and treat it as a promise by the political establishment that needs immediate fulfilment. Not delivering on this aspirational EHB could result in a government loosing popularity. Governments, through their technocrats, could therefore choose to lean towards 'reality' and what government can presently afford to avoid overpromising, stifling the visionary aspect of an EHB. It is therefore prudent for the policy maker to be clear whether the EHB is aspirational or not -- Luwabelwa et al., 2017, p26.*

This tension raises difficult choices for ministries of health on how to design and use their EHBs:

- On the one hand, as a tool that sets the vision for what *should* be found across all sectors and providers, to move towards as UHC and for poverty reduction, within a national unified heath system that provides comprehensive PHC, that identifies deficits to be met and clarifies health sector roles as a basis for engaging other sectors on health determinants.
- On the other had, as a tool to ration and allocate scarce resources, to align different funders and providers to an identified and more limited minimum package of services in the immediate on the basis of their economic efficiency in producing health benefits and in line with current budget resources.

Can it be used for both purposes? The 2018 regional review meeting supported this, while raising the question of what this implies for the criteria used in making decisions on the benefit package, and what financing and public health trajectory and triggers need to be planned so that the minimum does not become the maximum. While realised over the long term, the pathway has implications for current decisions, discussed further in *Section 10*, such as whether to focus resources on a wider benefit package in service levels that have pro-poor benefit, how to expand progressive financing and how to ensure equity in access to new services provided.

9.2 Issues affecting the design and development of the EHB

Generally, ESA countries currently apply an analysis of health burdens and cost-benefit or value for money analysis of interventions to identify the services included, while also taking on board policy goals and commitments and perceived priorities of stakeholders, including external partners and, to a more limited extent, communities.

Despite the diversity in their design methods, the EHBs in the region cover similar services for communicable and non-communicable diseases, maternal and child health and public health interventions, and ancillary support services. Various limitations are noted in the design, including in the adequacy and quality of population health, cost and cost benefit data, in the variation in methods and assumptions used for costing and the criteria for prioritisation of services, and gaps in evidence from the private-for-profit sector, and in other off-budget resource flows.

There was wide variation in both total and disaggregated cost estimates ($4-$83/capita at primary care level and $22-$519/capita, including referral hospital services). For some, the total costs calculated compare with the $60 per capita estimated by WHO in 2008 for health system costs, within national total health expenditure but above public sector budgets. For others, such as Swaziland, including the full costs of meeting the capital gap within ten years made the EHB unaffordable relative to the public sector or national health expenditure.

The 2017 regional meeting noted the need for transparency on the assumptions used and limitations in the costing methods, of working with a country working group/committee and including external peer review to widen confidence in the results. Further, while the process is presented as technical, it involves political decisions, implying processes for engaging political leaderships, communities and local implementers – including through local surveys, consultations and validation exercises – for them to give their inputs and for their formal adoption of the EHB, as is done in some countries by cabinet and parliament.

Should there be greater regional exchange on these methods and approaches? It would appear that regional exchange on costing methods and assumptions would assist to support costing methods that are credible to ministries of finance, national and external funders, and regional databases on commodity prices can assist in meeting data gaps. This could support the intention to update benefits and costings every five years in line with national strategic plans and to clarify capacity and funding gaps to be met in negotiating budgets for investments in the sector.

9.3 Issues affecting the use of the EHB

As a system measure, the EHB becomes known and relevant when used as a tool to strengthen public health planning, management and purchasing of services, for resource allocation and to monitor service delivery and outcomes. In other words, its quality and relevance depends in part on the learning from its use, linked to strategic planning.

Across the case study countries, use of the EHB was reinforced by its formal inclusion in development plans and health strategies, linking it to health sector planning, health budgeting, resource allocation and negotiations on financing with the treasury and development partners. In such processes it has been used for gap analysis of infrastructure, equipment and staffing; to guide human resource establishments and placements; to augment negotiations on funding for critical service areas, including sector-wide funding; to guide service quality and district health plans and budgets; to inform policy dialogue on the benefit package for national health insurance schemes and results-based financing; and to inform health sector performance indicators.

Notwithstanding this, the use has been relatively patchy in specific ESA countries, with numerous implementation challenges (see for example *Table 9*). These challenges have included the changing population health profile, with demand outstripping resources, inadequate personnel, equipment and infrastructure for the EHB services; gaps in operational guidance, communication and management capacities to apply it; fiscal and funding shortfalls, funds not trickling down through decentralised systems to local facilities and inadequate political buy-in.

Table 9: Challenges in implementing the EHB raised in the four country case studies

Shaded box indicates challenges noted in the case study

	Financial						Design				
	Limited funds	High EHB cost	Reliance on external funds	Strong International influence	Strategy for DRM/ HFS	District financial allocation	Need concise plans	Approach not integrative	Content unclear	Content not up to date	Purchaser-provider relation
Swaziland	■	■		■	■		■	■			
Tanzania	■	■		■	■	■		■	■		■
Uganda	■		(private)		■	■		■		■	■
Zambia	■	■		■				■			

Sources: Kadowa, 2017; Luwabelwa et al., 2017; Magagula, 2017; Todd et al., 2017.

At the same time the EHB is regarded as a tool to 'correct' some of these barriers, to profile the cost and capacity needs to equitably and efficiently deliver integrated services for UHC that respond to priority health needs, and that align different providers and funders around these goals.

In many countries, in part due to funding challenges, the use of EHB in strategic purchasing is still limited. It has been used as a tool for budgeting and planning at local government level, to guide priority setting and budgets and, in some cases, to purchase services from private, not-for-profit services through grants. Health facility reporting on performance on selected indicators of components of the EHB are used as a basis for public sector resource allocation to districts and facilities; performance contracts in referral hospitals have used EHB outputs and there is some discussion on the use of the EHB in performance contracts at levels beyond referral hospitals, including within plans for social health insurance and for direct facility financing. It has provided a wider lens for such purchasing, beyond more focused performance financing for specific vertical interventions.

The gap between the EHB intention as a basic entitlement and the reality of available financing has generated a range of responses in ESA countries. Some have explored new revenue sources from innovative financing (earmarked taxes, user fees from non-EHB services) and social/national health insurance.

The 2017 regional meeting noted that to fund a universal EHB, new funding options should be progressive (with tax financing the most progressive option) and should not segment population groups. Additional forms of revenue should be pooled with tax funding to allow for the risk and income cross subsidies needed to equitably provide the EHB to all. This also raises the need for inclusion of the EHB in all private voluntary insurance schemes and the contribution by these private schemes to the public-pooled funding for those elements of the EHB that are provided or used in public sector services by the clients they cover.

Monitoring and review of the EHB supports learning from practice, and iterative improvement of the EHB and can inform sector strategic planning. The findings indicate that monitoring could and should use the current routine health information system, complemented by periodic community and facility surveys, and not a separate data platform. However, accuracy, reliability, quality deficits and gaps in the data call for investment in the health information system, and critical use, dissemination and review of the evidence in planning, purchasing and monitoring of services.

Evidence is still limited of monitoring of the EHB being used to publicly demonstrate fair process and social accountability on services, linked in part to how far different stakeholders and communities are meaningfully engaged in the discussions on its design. Patient or service charters in some countries do not include public information on what services communities may expect to find at each service level. Only one country reports on the findings of service monitoring to parliament, and there is limited evidence of reporting to communities or public for social accountability. These are areas that would need to be strengthened if the 'leave no-one behind' SDG agenda is understood, beyond health outcomes, to imply the involvement of communities in decisions on their services.

10. IMPLICATIONS FOR FUTURE POLICY DIALOGUE AND PRACTICE

The findings from the programme of work have already begun to feed into policy dialogue processes within the countries involved. This section presents broad implications of the findings from the evidence and, as discussed, in the 2017 regional meeting.

> *This research points to the evidence that exists within the region for policy dialogue on universal health systems. It raises the usefulness of designing, costing, implementing and monitoring an EHB as a key entry point and operational strategy for realising universal health coverage and systems, and for making clear the deficits to be met.*

10.1 Using the EHB as a lever for equity and UHC at national level

At national level, setting an EHB as a universal benefit is consistent with policy goals to build universal equitable health systems. It clarifies legal or policy health promotive, preventive and care entitlements, delivered based on need and contributed to on the basis of ability. It is a potentially useful measure to align all actors to policy and strategy goals, defining and updating every five years what services, inputs, capacities and resources are needed to deliver these goals at all levels, and the deficits to address.

Given the changing population health profile, greater attention could be given to health promotion and prevention and greater engagement of high-level political actors, other sectors and communities from early in the EHB design. This would encourage all sectors to clarify their roles, responsibilities and interventions for 'health in all policies' and to show the health sector role in development and poverty reduction. This implies that the EHB is not simply seen as a technical measure, but as a product of political leadership and social values, calling for engagement of, and support from, political and community leaders.

EHBs operationalise resource and financing needs, opportunities and challenges that affect national goals and delivery of commitments to UHC. Addressing current and projected health burdens generates a saving in current and future costs to households and the economy, so that spending on services for prioritised health burdens represents an investment. The EHB costings can inform and support negotiations on innovative financing and sector-wide support and it can clarify which services need to be free at point-of-care to ensure financial protection.

To achieve the pooling of funds to provide for the income and risk cross subsidies needed for this, the 2017 regional meeting proposed that policy dialogue on health financing strategies and options be linked to plans for universal provision of the EHB. The participants expressed a preference for progressive tax financing and pooling of other social insurance and earmarked tax options, to avoid segmentation and ensure their application to a universal benefit for all. Together with operational guidance for its delivery, the EHB provides a standard for planning, budgeting and resource allocation, against which to assess and analyse capacity and skills gaps to deliver services.

While there has been public sector action on these potentials, to fulfil these functions nationally, the EHB should cover public and private sectors and engage all sources of revenue. The processes and methods for the design, costing and gap analysis thus need to be comprehensive and credible to all state and non-state funders and providers, updated every five years in line with national health strategies and medium-term expenditure frameworks, and demonstrating value for money (showing cost benefit, equity, quality and public health gain) for expenditures.

Funding gaps in the health sector have led some countries to develop a more limited 'minimum' package aligned to current public sector resources as a subset of the comprehensive EHB needed to meet population health challenges. In doing this, the equity implications of the rationing criteria applied must be transparent (such as whether resources are being focused on a wider benefit package in pro-poor service levels vs limiting benefits to specific conditions for all at all service levels).

There is also need to identify, including in health financing policies, what measures will ensure that the 'minimum' does not become the maximum, with the resource strategies, criteria and plans for the benefits to progressively expand over time to equitably meet public health needs. This raises many issues, including revenue generation strategies and measures to ensure fair contribution from public and private sectors towards pooled funding and EHB provision; EHB-oriented purchasing and performance contracts with non-state services; and measures to strengthen capabilities at pro-poor facilities and local government to absorb and manage resources to deliver service and health outcomes, and monitor capacities, delivery, coverage, health equity and value for money outcomes to inform improvements and give confidence to funders, providers, political levels and the public.

The monitoring system for this is vital. The 2017 regional meeting recommended that the existing health information and performance monitoring systems be strengthened. While this may call for investment in the system, it also calls for processes to engage the range of actors involved in sharing, disseminating and using information in the design, costing, planning and review of performance and outcomes of the EHB. This would encourage all to contribute to and use the information system and for social accountability on the delivery of policy goals.

10.2 Regional support for EHBs as a lever for equity and UHC

The exchange across countries in the process of this work in the ESA region highlighted potential areas of regional co-operation to support national processes and engage globally on the role of EHBs in building universal, equitable and integrated health systems. These included: regional repositories of publications and information for sharing knowledge (such as exist on the ECSA HC and EQUINET sites); exchanges across countries on practices to inform EHB processes, including through meetings of east African community, Southern African Development Community and ECSA HC; regional co-operation on training in key skills areas and regional forums involving parliamentary committees on health and technical actors to raise awareness, share learning and bring attention to knowledge gaps.

A regional guidance document, with links to existing resources, was proposed as a useful tool on the roles, design and costing approaches, assumptions and methods and issues to consider in implementing EHBs, on methods for assessing service readiness and capacity gaps and methods and indicators from the health information system and facility surveys for monitoring EHB performance.

Further, a regional database of commodity prices and a regional pool of multi-sectoral expertise on EHB design and costing would support national processes. As a measure that operationalises the system demands and deficits to be met for countries in the region to deliver UHC, the EHB also provides a useful lens in global engagement and negotiations and could be integrated within the regional processes for global health diplomacy.

Finally, this regional and country research in EQUINET on EHBs pointed to a significant body of evidence already present in the region for systems analysis and policy dialogue. There were also knowledge gaps, such as on the contribution of and policy measures for private sector involvement in EHBs, the methods for community inclusion in EHB processes, the triggers and transitioning processes for moving from 'minimum' to comprehensive EHBs, and how to use EHBs to engage wider sectors for health in all policies.

The involvement of ministries of health as researchers in this work, while time consuming and demanding for already busy personnel, brought a policy and practical lens to the research and policy dialogue, pointing to the value of embedded implementation research to inform such strategic policy and service processes.

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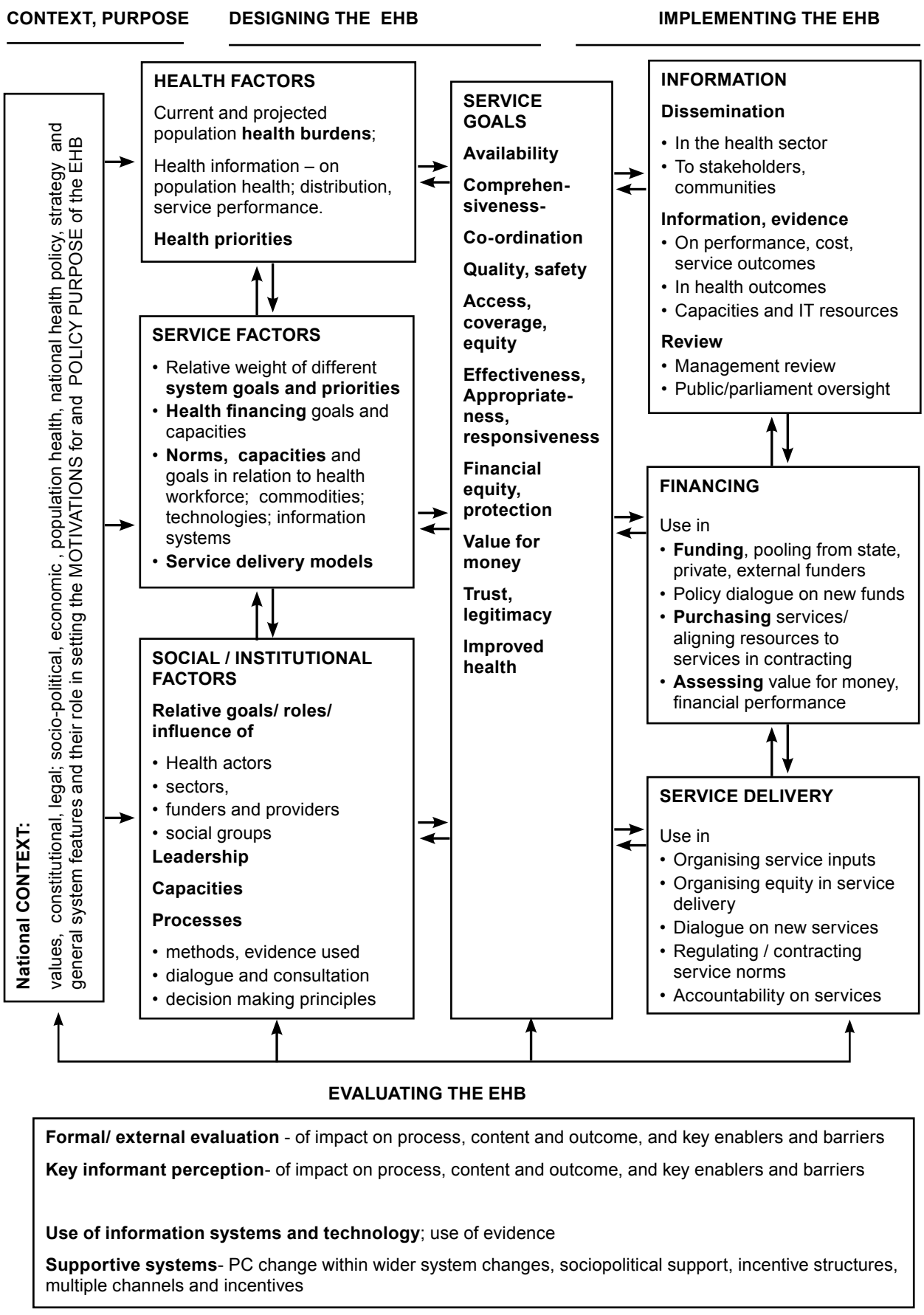
ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BHCP	Basic Health Care Package
CBOH	Central Board of Health
ECSA-HC	East Central and Southern Africa Health Community
EHB	Essential Health Benefit
EHCP	Essential Health Care Package
EHP	Essential Health Package
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESA	East and Southern Africa
GDP	Gross Domestic Product
GoU	Government of Uganda
HC	Health Centre
HIV	Human Immunodeficiency Virus
IDRC	International Development Research Centre, Canada
IHI	Ifakara Health Institute
LGA	Local Government Authority
MOH	Ministry of Health
NCD	Non-communicable Disease
NEHCIP-TZ	National Essential Health Care Interventions Package - Tanzania
NHCP	National Healthcare Package
PHC	Primary Healthcare
PO-RALG	President's Office - Regional Administration and Local Government
SDGs	Sustainable Development Goals
SWAP	Sector-wide Approach
TARSC	Training and Research Support Centre
TEHIP	Tanzania Health Intervention Programme
THE	Total Health Expenditure
UN	United Nations
UNMHCP	Uganda Minimum Healthcare Package
UHC	Universal Health Coverage
URT	United Republic of Tanzania
WHO	World Health Organization

APPENDIX 1: CONCEPTUAL FRAMEWORK FOR THE WORK



APPENDIX 2: COUNTRY PROFILES

Table A1: Health system structure

	Levels of Care Figures in brackets denote number of health facilities
Swaziland	1. National Referral Hospitals (3) 2. Regional Referral Hospitals (5) 3. Health Centres, Public Health Units (PHC I) 4. Rural Clinics and Network Outreach Sites (PHC II) 5. Community Based Care (Rural health motivators, faith-based healthcare providers, volunteers and traditional practitioners) Total 287 facilities, government owning the majority; other owners include mission, industry, private owned by nurses and doctors, and NGOs; Limited decentralisation
Tanzania	1. National Hospitals 2. Zonal Referral Facilities 3. Regional Referral Hospitals 4. PHC and District (community based care, dispensaries, health centres, district hospitals) 8,215 health facilities, 84% are owned by the public sector. Decentralised administration
Uganda	1. National Referral Hospitals (2) (under Ministry of health) 2. Regional Referral Hospitals (14) (under Ministry of health) 3. General Hospitals (131) (From this level below under district local government) 4. Health Centres IV (constituency) (193) 5. Health Centres III (1,250) 6. Health Centres II (3,610) 7. Community Health Teams Most health centres government owned; other providers include faith-based and private for profit providers, as well as traditional practitioners. Decentralised administration
Zambia	1. Tertiary Hospitals (National) (6) 2. 1st (81) and 2nd (24) level Hospitals (District and Province) 3. Health Centres (1,540) and Health Posts (309) (PHC) Largely state or church (not-for-profit) owned and funded. Decentralised administration

Source: Magagula 2017; Todd et al., 2017; Kadowa 2017; Luwabelwa et al., 2017

Table A2: Summary of the names and defined objectives of EHB in the 16 ESA countries

Country	EHB Name	EHB Objective
Angola	Essential Health Services Package (EHSP)	Strengthening the health system. To increase use and availability of priority services in Luanga/Huambo provinces
Botswana	Essential Health Services Package (EHSP)	Establishing promotive, preventative, curative and rehabilitative health interventions to achieve UHC
DRC	Essential Health Care Services	"provide essential health care services for the whole population, whilst strengthening government health management teams"
Kenya	Essential Package for Health (KEPH)	"creating an affordable, equitable, accessible and responsive health system"
Lesotho	Essential Service Package	"health interventions that address priority health, health-related problems that result in substantial health gains at low cost"
Malawi	Essential Health Package (EHP)	EHP to tackle three pillars: equity, cost-effectiveness and systems-strengthening and efficiency
Namibia	Minimum health service package	Basic social welfare and health care is the right of all citizens
South Africa	Prescribed Minimum Benefits Package (PMB)	"… the minimum level of care that is to be funded by all private medical insurers…"
Swaziland	Essential Health Care Package	Enabling "effective and equitable health service delivery"
Tanzania	National Package of Essential Health (NPEH)	Integrating cost-effective interventions that address the main health problems and risks
Uganda	Minimum Health Care Package (MHCP)	Cost-effective intervention to meet health needs and services, particularly of women and rural populations
Zambia	Basic Health Care Package	Strengthening the health system and achieving equity, cost-effectiveness and quality health
Zimbabwe	Essential Health Benefit/ Core Health Services	All citizens of Zimbabwe should have the highest level of Health and quality of life

Source: Todd, Mamdani and Loewenson., 2016. No information found for Madagascar, Mauritius, Mozambique

Table A3: Documents referencing motivations for development of the EHBs, 1960-2017

	1960-90	1990-2000	2000-10	2010-20
International	1978 Alma Ata declaration 1980s onwards: Structural Adjustment	1993 World Bank Investing in Health 1998 World Development Report,on evidence-based, cost-effective planning	2000: UN General comment 14 on the right to health 2000-2015 MDGs Especially MDG4 and 5 2008 Ouagadougou Declaration on PHC in Africa	2013 onwards: UN Sustainable Development Goals 2013 (especially SDG 3)
Swaziland		2000 Council for Health Services Accreditation for Southern Africa (COHSASA) assessment indicating 40% of services substandard	2005 Constitution setting health care as a right 2010 concerns on uncoordinated, inequitable services, 50% of recurrent health budget directed to hospitals, and 20% to clinics	2007 National Health Policy, 2010 Health infrastructure policies, health worker training projections to address shortages and ensure service availability
Tanzania	1967 Arusha Declaration 1982 Local Government Reform Act; 1990 National Health Policy	1994 health sector reforms 1999 programme of work 2005 Development Vision 2025	2001 Community health fund 2005-2010, 2011-2015 National Strategy for Growth and Poverty Reduction 2006 + Results based financing 2003; 2009 Health sector strategic plans 2007 National Health Policy 2008 human resources for health plan 2007; 2011 Primary Health Sector Development Plan, Comprehensive Council Health Plans	2015-2018 Big results now 2017 Client Service Charter 2017 Decentralised District Facility Financing Current: Health Financing Strategy
Uganda		1999/2000-2009/2010 National Health Policy	2000/01-2004/05; 2005/06 Health sector strategic plans	2010/11-2014/15 Health sector strategic plans 2010-2020 Second National Health Policy
Zambia		1991-2 Health Sector Reforms	2006 Sixth National Development Plan and Vision 2030 2006 Twelve focus areas and standards in the National Health Strategic Plan	

Sources: Magagula 2017; Todd et al., 2017; Kadowa 2017; Luwabelwa et al., 2017

Table A4: Content by level of care for EHBs in selected ESA countries

A4a. Content by level of care for the most recent EHB in Zambia

Service level	EHB content for that level
Primary (community)	Six key areas: health and wellbeing; children, young people and families; acute care; long-term conditions; rehabilitation; end-of-life care. Also: health promotion; the use of rapid diagnostic test for malaria, HIV, diabetes and kidney disease; growth monitoring and immunisation of children; screening of cancer, diabetes, hypertension; hospice and home-based care.
Primary (health post)	Limited diagnostic capabilities; a range of promotive and preventive activities and a limited number of curative and rehabilitative activities. The curative activities include the treatment of uncomplicated malaria, acute diarrheal diseases, upper respiratory tract infections, among others, and the provision of first aid. Responsible for follow-up and monitoring of adherence to treatment for chronic ailments such as cancer, diabetes, hypertension, TB and HIV. Expected to map households in their locality to identify homes with people that need monitoring and assistance, to encourage screening, and ensure timely immunisations.
Primary (health centre)	Include: antenatal, postnatal and neonatal care, family planning; routine expanded programme of immunisation; growth monitoring; management of childhood diseases; treatment of malaria, TB, including DOTS; ART, VCT; NCD surveillance and screening; treatment of minor injuries, minor surgeries; and the dispensing of essential drugs.
First- level referral	Include: medical, surgical, obstetric and diagnostic services. The clinical services at level 1 should support health centre referrals. The entry point for curative and rehabilitative services provided at the secondary and tertiary levels of care..
Provincial/ regional hospital	Provide services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental, psychiatry and intensive care. Referral centres for first level institutions, providing technical support to referring facilities.
Central hospital	Provide services available at level 2 facilities and other specialised services (oral health, NCDs, advanced diagnostic and rehabilitative services. Should be at least one per province; capable of providing and/or supporting pre-service training programme(s), including attachments for highly skilled health workers, and providing a research environment.
Tertiary hospital	Provide specialised healthcare services, training and research. Currently, there are four facilities offering specialised services: Cancer Diseases Hospital (CDH) for cancer, Chainama Hills Hospital (CHH) for psychiatry, Arthur Davidson Hospital (ADH) for children and University Teaching Hospital (UTH).

Source: Zambia Ministry of Health, 2006 in Luwabelwa et al. 2017

A4b: Content by level of care for the EHB in Uganda

Service level	Coverage population	EHB content by level of care
Primary (Community) Health Centre I)	Covers 1,000 people	Mobilisation to improve people's health, data collection, health promotion, hygiene, sanitation, nutrition, child growth monitoring and model homes.
Health Centre II	Provides coverage to 5,000 people	Immunisation fixed and mobile, antenatal care, health education, sanitation and disease prevention, screening for health risks/diseases, family planning, basic first aid, monitoring service delivery, general OPD services, emergency deliveries, plus all functions of Health Centre I.
Health Centre III	Provides coverage to 20,000 people	Minor surgery, maternity services, inpatient services, sanitation, treatment of common diseases, static immunisation, minor dental treatment, sexual reproductive health, basic laboratory services+ Health Centre II functions.
Health Centre IV	Provide coverage to 100,000 people	Supervision of Health Centre III and II, centralized data collection, analysis of health trends, disease surveillance, simple surgery including Caesarian section and life-saving surgical operations, blood transfusion, ultra sound examinations for abdominal conditions, standby ambulance, mortuary, plus all functions of Health Centre III for the target population.
General Hospital	Covers 500,000 people	Plain X-Ray examinations, all general medical and surgical conditions, specialist services, plus all functions of Health Centre IV.
Regional Referral Hospital	Covers 1,000,000 people	General and specialist services such as psychiatry, ear, nose and throat (ENT), radiology, pathology, ophthalmology, higher level surgical and medical services including teaching and research
National Referral Hospital	Covers >1,000,000 people	Provide comprehensive specialist services and are involved in teaching and health research.

Source: GoU, 2016c in Kadowa 2017

Table A5: Methods used to define the EHB in the country case studies (*)

Country	Methods used to assess the disease burden and service capacities	Methods used to prioritise and define the package	Methods to integrate stakeholder input
Swaziland	Baseline data on Service Availability Mapping (2013) provided data on availability and quality of health services. Human resource projections, survey reports and programme guidelines also used.	Review of policy documents and evidence to define priorities and minimum health services, taking into account the disease burden, cost-effectiveness, affordability and service delivery models that maximise synergies and linkages. Criteria applied for decisions included maximising health outcomes; improving health equity; improving responsiveness to clients' health needs and preventing and managing disease.	A committee was set up involving, MoH and service managers at all levels, private for profit, faith based and NGOs, training Institutions, technical and development partners to review the EHB. A multi-disciplinary national task team was set up in 2017 to update the package with interactions on-going.
Tanzania	TEHIP pilot findings provided learning for further development of the EHB. The burden of disease was used to identify priority service areas. The current NEHCIP-Tz adds a social determinants of health and patient-centred approach, with more focus on preventive, and promotive services (See Box 2). It also organised 'disease clusters' reflecting burdens and needs	Decisions on the benefits to include took into account as criteria development and health policies including for equity, universality, access and efficiency; health sector strategic plans; health system reforms including for quality assurance and decentralisation, referral guidelines, what could be provided for in new financing mechanisms such as the Community Health Fund and public health priorities. The EHB was designed to be used across all health facility levels and structures; to guide and support local capacities to ensure services; plan, and budget for their implementation in an integrated approach. In the latest iteration diseases are clustered for continuity of care in services, and to inform discussions on proposals for a single national health insurance plan to finance the 'minimum' health services.	The consultations involved MoH, PO-RALG, LGAs, communities and development partners. Districts and council health services were identified as key stakeholders, although they and communities had more limited involvement when the benefit package was finalised at central level. The NEHCIP had final approval from the cabinet and parliament.
Uganda	Cost-effective interventions were identified for the burden of disease, A 1995 burden of disease study identified the top ten causes of morbidity and mortality. The cost effectiveness of interventions for these top 10 cases of morbidity and mortality were assessed.	The criteria applied in the decisions on the benefits were those that provide 'best' value for money in reducing the disease burden, and that could be implemented in the decentralised structures. The UNMHCP also included as criteria investment in services that contribute to reducing poverty as a result of ill-health and that reduce out-of-pocket payments for health care, applying an equity lens, to meet needs universally.	Ministries of health, finance, public service, local government, water, agriculture and education were consulted, with, parliament, international agencies, development partners, civil society and private faith based and for-profit sectors. The proposals were reviewed by working groups and in the health sector annual joint review mission.

Country	Methods used to assess the disease burden and service capacities	Methods used to prioritise and define the package	Methods to integrate stakeholder input
Zambia	The process of developing the BHCP in Zambia involved eight stages. Firstly, definition of the main health problems: The frequency of diseases for which there were data from the health information system at health centres and hospitals out-patients were listed. For some diseases, population data from Zambia and studies from Mozambique and Zimbabwe were triangulated. Disability Adjusted Life Years (DALYs) lost were calculated and listed for each disease or group of diseases. All interventions, including prevention interventions like family planning, were listed by service level and expert assessment and brainstorming used to assign them to specific diseases. The inputs for every intervention were identified in terms of skills, material, equipment and drugs, first by working groups, and then validated by service managers.	Interventions were prioritised according to efficacy and policy priority, quality and demand. Costs were estimated for all inputs, together with cost-effectiveness and cost per capita (See Section 6.2). The decision on included benefits was evidence based and involved several stages. Interventions were ranked by cost-effectiveness. Services were also prioritised if they had high impact on key health problems, could be delivered with a quality of health care in an integrated health care system, addressed equity, accessibility, cost-effectiveness, and could build accountability to all stakeholders in the health system. Special consideration was made for interventions that have public health benefit and that have long-term effect on survival and quality of life, such as care for patients with AIDS, nutrition, family planning and immunisation. An analysis was conducted to identify what was needed medicine, staffing and equipment was required to provide the defined services and the implications for human resources, infrastructure, equipment, supplies and health financing were identified. In later iterations of the EHB the costs were also compared against the total health budget, and against an assessment of services currently provided.	The proposals were reviewed by external consultants in 2004 and 2009 and consultations held with MoH departments, provincial and district health offices, and ministries of defence, home affairs, finance, community, local government were involved, as well as statutory boards, non government organisations, private sector providers, universities and co-operating partners in the health sector.

Sources: Magagula 2017; Todd et al., 2017; Kadowa 2017; Luwabelwa et al., 2017

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; HEPS and CEHURD Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; SATUCC and NEAPACOH

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