The role of an essential health benefit in the delivery of integrated health services: Learning from practice in East and Southern Africa

Regional research workshop
REPORT

November 27-28 2017
Zanzibar, United Republic of Tanzania

Regional Network for Equity in Health in East and Southern Africa (EQUINET)

through Ifakara Health Institute and Training and Research Support Centre

in association with the East, Central and Southern African Health Community

with support from IDRC (Canada)

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The report was prepared by Faye Richardson and revised and edited by Masuma Mamdani and Rene Loewenson.

Please see Section 7 pages18-19 for the recommendations

1. Background and objectives

An Essential Health Benefit (EHB) is a policy intervention designed to direct resources to priority areas of health service delivery to reduce disease burdens and ensure equity in health. Many east and southern Africa (ESA) countries have introduced or updated EHB in the 2000s. 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 (MoH) in Swaziland, Tanzania, Uganda and Zambia, implemented research to understand the facilitators and the barriers in nationwide application of the EHB in resourcing, organising and in accountability on integrated, equitable universal health services. A regional review of literature on EHBs in the four country case study reports from the research programme are available on the EQUINET website (www.equinetafrica.org)..

This report presents the proceedings of a regional consultative meeting convened on November 27-28, 2017 to present and discuss evidence from the research programme. The regional document review covering 16 east and southern African (ESA) countries, the findings from the country case studies in Swaziland, Tanzania, Uganda and Zambia, experiences from South Africa and Zanzibar and a regional synthesis of the evidence from across the programme were presented at the meeting, and background documents made available.

The meeting aimed to:

a. Identify issues arising in the motivations for developing the EHB; the methods used to develop, define and cost them; their dissemination, communication and use within countries, including in budgeting, resourcing and purchasing health services; and, in monitoring health system performance for accountability;
b. Identify policy-relevant and operational national and regional level recommendations on the role, design and use of EHB; and,
c. Propose areas for follow up policy, action and research.

The meeting was convened by Ifakara Health Institute (IHI) and the Training and Research Support Centre (TARSC) for EQUINET, in association with the ECSA Health Community and with support from IDRC Canada. The programme is shown in *Appendix 1*. Delegates included senior health officials from national and regional organizations, researchers from IHI and TARSC and from IDRC Canada. The delegate list is shown in *Appendix 2***.**

2. Opening

Delegates were welcomed to the meeting by *Masuma Mamdani, Chief Research Scientist, IHI* who chaired the opening session. Delegates introduced themselves, their organization and their EHB related work.

Professor Yoswa Dambisya, Director General, ECSA-HC welcomed participants and thanked the Zanzibar Ministry of Health for hosting the meeting. Noting the missed opportunities of past health initiatives, such as the 1978 Alma Mata declaration of “Health for All” and the still unmet targets of the 2015 Millennium Development Goals (MDGs), he observed that the Sustainable development goals (SDGs) provide a renewed opportunity to regroup and focus policies on UHC to ensure that ‘no one is left behind’. He observed that ensuring universal health coverage (UHC) is a challenge, given that most ESA countries are financially constrained and have not yet met their Abuja commitments of allocating 15% of their government budget to health. Within this context, he noted that EHBs have a role to play in operationalizing policies and promoting best practices for African countries to fulfill their national and international commitments, and to engage and align global partnerships. He appreciated the opportunity provided by the meeting to learn from the experiences of EHBs in the participating countries and at regional level. He observed that ESCA-HC values its partnership with EQUINET and other partners in the meeting as they provide an opportunity to exchange and collectively benefit from context relevant research evidence. He further acknowledged the timely support from IDRC Canada to the region to advance learning on and effective use of EHBs to support the health agenda of the region.

Dr Oberlin Kisanga, Head, HSR Secretariat, MoHCDGEC, Tanzania, thanked organizers for providing this opportunity to meet and share evidence and experiences from the region for health development and UHC. He mentioned that health is important for national and regional development, and appreciated the opportunity for countries to share experiences of EHB in the region. Dr Kisanga observed that the programme provides opportunity to develop a regional approach for reaching UHC. He reiterated that our countries are not that different, and by coming together to promote shared learning, we can attain the goal of UHC. He appreciated further the building of regional approaches from country experiences, sharing new approaches, exploring how countries are organizing and using tools such as the EBH to reach everyone in the country with health care. He thanked the organizers for holding this forum in Tanzania, welcomed delegates and introduced his colleague from the Ministry of Health (MoH) Zanzibar.

Hon Halima Abdulla Salum, Deputy Principal Secretary, MoH - Zanzibar greeted and thanked the meeting delegates for travelling to Zanzibar for the meeting. She expressed her appreciation as local host of the meeting of the efforts of EQUINET, ECSA-HC, IHI, TARSC in providing information and guidance, through various researches, to strengthen health services and to provide health for all, and thanked IDRC for its support. She explained that in Zanzibar, the EHB concept is integrated within national strategies and health policies that aim to improve the health and sustain social well-being, particularly of women, children and other vulnerable groups. Various strategies have been developed to ensure effective health coverage. Zanzibar provides a wide range of health services, from maternal newborn and child health services, with free antenatal care; prevention of mother to child transmission (PMTCT), malaria prevention - nets, testing; immunizations for all children under 5 years to services for chronic conditions, including methadone treatment for intravenous drug users. She expressed her hope that the meeting develop specific recommendations on how to advance EHBs in the region.

Masuma Mamdani, IHI, provided a brief overview of EQUINET, which was formed in 1998 by a network of like-minded professionals, civil society members, policy makers and state officials aiming to advance health equity and social justice through research, analysis, networking and dialogue, now covering 16 ESA countries. EQUINET's steering committee leads and facilitates the work in five major cluster areas: 1) strengthening social empowerment in primary health care (PHC), including through health literacy, health centre committees; 2) fairly resourcing national health systems, both in terms of fair financing and the distribution of health workers; 3) engaging globally on health promoting policies and global health diplomacy; 4) promoting health rights and public health law; and, 5) implementing cross-cutting equity analysis, including of health equity in districts and in urban areas. She explained that the work on the EHB is located in this fifth cluster, given its integrating role in promoting equitable health systems . She also highlighted that EQUINET uses a range of research methods, disseminates strategic information through regional meetings. and the reports, newsletter, publication databases, grant calls. available on its website.

Masuma indicated that the regional research on EHBs was undertaken in response to expressed interest by policy makers from ESA countries, and that this is the first meeting of all the research partners to share and learn from each other's experiences. She recapped the meeting aims, presented in the previous section, and the two-day programme, that was adopted by delegates.

3. Motivations and analytic framework for research on EHBs in ESA

Dr Rene Loewenson, Director, TARSC and Cluster Lead, EQUINET added her appreciation for the constructive introductory remarks, conveyed the apologies from the MoH-Zimbabwe who were unable to attend, and noted with regret the passing in the week of Dr. Timothy Stamps, a previous Minister of Health, a 'founding thinker' who encouraged EQUINET's formation in 1997 and a health champion in the region.

She reiterated that the challenges in ensuring equitable health care are fairly common in the region and the commitment to UHC provides a window of opportunity for longer-term solutions rather than quick fixes. She summarized the challenges for equitable, universal health systems as:

- Social inequalities in health and access to care and social determinants driving health burdens and economic growth not automatically reducing poverty and inequality;

- A double burden of communicable and rising non-communicable diseases (NCDs) and demands for reproductive, sexual, maternal and child health. She noted that people often have multiple conditions, making vertical single disease approaches inefficient in responding to people's multiple needs. She cited evidence suggesting that inadequate management of chronic diseases will in the long run result in unaffordable costs to the health system, the economy and households.
- Increased social literacy, rights and knowledge / technical opportunities for health with growing expectations of universal access to health services, combining with underfunded, under resourced public sector health services and still unmet MDGs and global commitments to UHC.

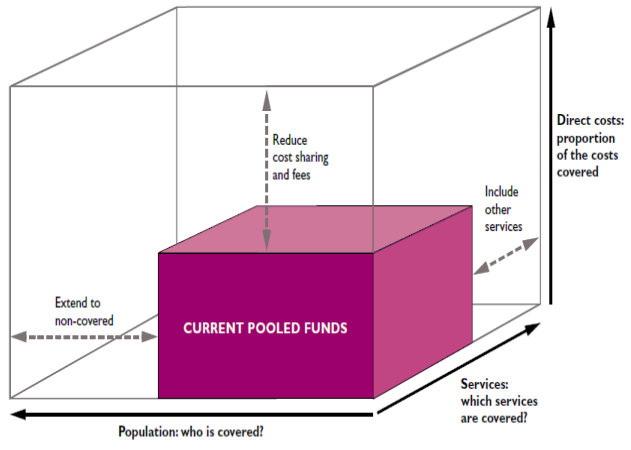
This raises the question of how an EHB assist to address these challenges. Rene identified the EHB as a positive list of specific defined benefits and a policy intervention designed to direct resources to priority areas of health service delivery, to reduce disease burdens and support health equity… and UHC. EHB exist across the region in place in different forms and with different names, making it pertinent to gather and share experiences of EHB within the region. To systemize this analysis within and across countries, she presented the analytic framework developed for the project that addressed the context, motivations for and purpose of the EHB, the design, costing and services covered, funding and use in strategic purchasing and other dimensions of implementation.

The regional literature review of 16 ESA countries (EQUINET Discussion paper 107), raised four major purposes for EHB across the region, with some variability across the countries shown in the report :

- Based on *rights* (constitutional, public health law): to clarify public entitlements from all providers.
- Based on *policy commitments* to equity and UHC (SDG3): to reduce disease burdens, support health equity and universal care.
- Based on *financing concerns*: to negotiate, coordinate and direct scarce resources to purchase prioritized cost-effective services, provide free at point of care (insured/public funded).
- Based on *efficiency and public accountability*: to monitor and report on delivery, service performance and quality.

She indicated that moving towards UHC calls for the three dimensions shown in *Figure 1* to be considered to expand who is covered, to reduce impoverishment from fees and to widen the services provided to address new health burdens. She explained that the EHB, in its design, answers the question of which services are covered; and in its design and implementation addresses the financing and coverage of services. It thus has potential to contribute to UHC in the region.

Figure 1: Dimensions relevant to UHC



Source: World Health Report 2010

In the ESA region, the desk review showed that the EHBs have common areas of service focus, but varied methods for design and costing and a wide cost range from $14-$25/capita at primary care level to $40-$74/capita, including referral hospital services. However she observed that the regional document review indicated a number of limitations in this role: with the EHB mainly implemented in the public sector, with limited application in the private sector; clearer at lower (primary) level than higher referral levels; with limited use in budget negotiations and strategic purchasing; and an implementation gap.

The review and analytic framework raised questions to address in the country work:

- What were the main policy purposes for the EHB and *how did this change over time*?
- How (and by whom) are the EHB identified, prioritized and costed? *With what challenges?*
- What services are included, in what sectors and levels and at what cost? *What has influenced this?*

- How is the EHB being disseminated and used in providing, funding, purchasing, monitoring and accountability on services? *What factors affect implementation?*
- Who is involved in the technical work, policy decisions and in tracking performance of the EHB?
- What impact has the EHB had in relation to the policy, financing and service goals?

These questions were explored in the country case studies by teams from Swaziland, Tanzania, Uganda, Zambia. These case studies would be presented in the meeting, as would a draft regional synthesis was carried out by the team. It was intended that the work be reported in the ECSA HC and SADC to inform other countries. The DG ECSA HC observed that it is opportune this dialogue is happening in Zanzibar since this is where the next Health Ministers' Conference will be held as one opportunity to share in the regional learning on EHB. It was also raised that the meeting provides an opportunity to strengthen regional evidence and analysis to influence global discussions on UHC.

4. Country experiences of EHBs

This section outlines the case study presentations by representatives from Uganda, Zambia, Swaziland and Tanzania of their EHB experience. The session was chaired by *Dr. Anna Nswilla, Asst Director, District Health Services, President's Office, Regional Administration and Local Government, Tanzania* in the morning and *Dr. Samwel Magagula, MoH, Swaziland* in the afternoon.

4.1 The Uganda National Minimum Healthcare Package (UNMHCP)

Dr Isaac Kadowa, Principal Medical Officer, MoH, Uganda presented the Uganda case study (See EQUINET, Discussion Paper No. 110 for the full report). It was introduced in the 1999 Health Policy and includes cost-effective interventions for the most prevalent conditions. It was motivated by:

- Inability to implement PHC holistically after adoption of selective vertical packages for primary care due to difficulties with implementing the PHC concepts of Alma Ata Declaration and international financing of prioritised selected health interventions after the 1990s macro-economic restructuring.
- Limited resources and a high disease burden, raising demand for cost-effective interventions to achieve value for money, particularly for ten preventable diseases accounting for over 60% of total national mortality.
- An intention to reduce poverty, identified to be the main underlying cause of poor health in the country; following decades of civil strife, together with concerns for equity in service access and coverage, with services made available on the basis of need regardless of age, gender or location, accessed without charge at point of care, guaranteed by government and funded by tax revenue.
- To address political considerations and accountability.

Operationalized in 1999, the UNMHCP was revised in 2010. Dr Kadowa outlined key elements in designing Uganda's current EHB within four clusters from primary to referral hospital:
1 - Health Promotion, Disease Prevention and Community Health Initiatives;
2 – Maternal and Child Health;
3 - Control of Communicable Diseases; and
4 - Control of NCDs/Conditions.
Dr. Kadowa explained reaching a consensus on the development of the UNMHCP was a long, contentious, participatory and consultative process taking over 3 years, involving a wide range of stakeholders and views. He observed that it became feasible when it was agreed within a sector-wide approach (SWAp) for integrated planning, budgeting and implementation. He outlined Uganda's "ingredients approach" used to determine the cost of UNMHCP, detailed in the case study report, based on costs of service inputs at different levels, including recurrent costs (personnel, drugs, supplies, supervision, in-service training, IEC and social marketing, etc). The original costing estimated $28/capita to deliver UNMHCP, revised in a second costing in 2009 to $47/capita.

He outlined the many ways UNHCP has been used in the various processes and areas: to set service priorities for the national development plan and health sector planning, budgeting, resource allocation and negotiations on financing; to guide health worker needs and placements; in the design of the proposed National Health Insurance Scheme and its benefit packages and in discussions on results-based financing (RBF). It has been used to guide planning and resource allocation to district local

governments, to purchase services from private not-for-profit (PNFP) providers and to align partner funding to national health priorities, including in the SWAp. It has been used to develop disease and programme plans, national treatment guidelines for common conditions, essential drug lists and infrastructure and equipment requirements for each level of care. The UNMHCP has thus been used to develop key health sector performance indicators and has provided a platform to discuss service delivery. Indicators derived from the UNMHCP services are monitored and with service delivery assessments are tracked in a Joint Budget Support Framework accountability process, by the Uganda Bureau of Statistics through periodic surveys, by the MoH in quarterly and annual performance reviews and by parliament and others to scrutinize health sector performance and obtain client feedback, including by mobile phone, with a toll-free anonymous hotline number to call or SMS.

In summary, he identified in Uganda's experience *a number of good practices:* in the consensus building consultations resulting in broad support for UNMCHP; in comprehensive costings done on two periods; in "ring-fencing" selected prioritised areas for PHC funds not subject to cuts and in the impact of applying it in reduced prevalence of targeted conditions/diseases.

At the same time there were *challenges,* including the breadth of the UNMCHP relative to available resources, falling public funding and inadequate and inequitable health worker distribution; persistent coverage gaps and out-of-pocket costs undermining equity; poor quality of care and accountability for service performance, limited health worker incentives to improve performance or workload and difficulties with managing these issues in decentralized health services.

Dr Kadowa noted the need to address the role of private sector/providers in the delivery of the UNMCHP; its use in resourcing health system building blocks and in managing social determinants of health. He recommended nationally and regionally for the EHB to:

- Consider shifting from the traditional health sector package to a multi-sectoral "health in all policies" approach to address social determinants of health and life cycle needs of households.
- Address current and new and re-emerging diseases and risk factors contributing to disease burden.
- Be used to strengthen monitoring, regulation and incentives for private sector providers to achieve efficiency, quality and curtail rising costs.
- Be used to advocate for increased government funding to the health sector and align partner funding through a SWAp arrangement and promote pre-payment approaches; and
- Be supported by incentives to recruit and retain skilled health workers for better performance.

He proposed that the regional synthesis of the country case studies be used to inform policy regionally and a harmonized regional EHB prototype for ESA countries to adopt/adapt with the aim of moving towards UHC, with specific regional studies to address EHB knowledge gaps.

In the discussion that followed delegates noted the significant role of private sector services in Uganda due to poor quality public sector services, but with limited state subsidy for private non-for-profit services. Dr Kadowa noted the intention to extent the UNMCHP into the private sector, with a public, private partnership unit in the MoH to take this forward and co-ordinate and align off-budget financing. Delegates agreed on the need for attention to the application of EHBs in the private sector. They also noted the need for monitoring reports and audits to be publicly reported for them to be used to advocate performance improvements; and for regional training of key health workers to address the shortfalls affecting service delivery across ESA countries.

4.2 The role of the EHB in the delivery of integrated health services in Zambia

Mr. Muunda Palale, Director of Budget and Costing, TaMuunda Associates, Zambia presented the Zambia case study. (For full information see EQUINET, Discussion Paper No. 111). He outlined the development and motivation of EHB in Zambia, starting in 1991 with health sector reforms and continues as a work in progress. The EHB was a planning tool to assist in identifying cost-effective interventions and for a fair distribution of skills, drugs, equipment and other resources for health service delivery. He reviewed each stage of EHB's development with an overview of the methods used, the players involved in the process and issues/challenges in the process, including in the latest steps from 2016 to validate, prioritize, revise, cost and compare information to update the EHB, albeit with still limited progress. He explained that a debate continues on the purpose, scope and content of the benefit package,

The case study thus reported largely on the 2003/04 EHB. It was costed by calculating for each service level the specific current and projected costs based on protocols, including for preventive care and administration and labour costs. The total per capita cost for EHB was $22.70 (2004); for health centers - $7.39/capita, district hospitals - $7.45/capita, general hospitals - $2.57/capita and third level - $1.47/capita. He described the use of EHB in budgeting, financing and in resource allocation. He also noted some of the challenges. The difficulties encountered include: the limitation of resources, lack of management confidence in the EHB and negotiation of budget allocations, and the incomplete state of the EHB weakening its use as a financing guide. He explained, however, how EHB can be used to ensure allocated resources are used for their intended purpose with regard to quantities, timing and overall efficiency (variance analysis) and can be a standard by which performance can be measured and remedial actions taken. He also noted that this use can be limited if the costings are outdated.

Mr Palale outlined positive experiences on the EHB in Zambia in:

- Engaging specialists in its development with clear terms of reference for the development process.
- Consulting and involving grassroots people to know their aspirations and gain input and buy in.
- Establishing capacity and tools within the MoH to regularly update the EHB and pricelist, while noting the need for permanent staff for this, in line with changing needs and demographics
- Building genuine political will to use the EHB as a tool for priority setting, planning, budgeting, monitoring, evaluating and accountability.

He also described some of the major challenges faced, in the knowledge gaps, incomplete records, outdated data, lack of specialists, a weak information management system, untrained staff, still limited public consultation and political will, despite efforts made and designing interventions from an academic vs practical lens.

In conclusion, he offered the following recommendations from the Zambia experience:

- To institutionalize EHB, for the EHB to be used by every health institution as a primary guide.
- To invest in the health information system and the technology to provide accessible, timely and accurate information, given their critical role in the reliability and effectiveness of the EHB.
- To invest in staff training in all health institutions to understand the EHB purpose and functions.
- To ensure for public acceptability that the EHB benefits are guaranteed, and delivered consistently and fairly.

4.3 The Swaziland Essential Health Care Package (EHCP)

Dr Samuel V Magagula, Director of Health Services, MoH, Swaziland presented the Swaziland case study. (For full information see EQUINET, Discussion Paper No. 112). He outlined the Kingdom of Swaziland economic, demographic and health indicators, noting the double burden of communicable and non-communicable diseases.

The Swaziland EHCP purpose is stipulated in the country's Constitution - *All practical measures shall be taken to ensure the provision of basic health services to the population is implemented* - and the national health policy. The EHCP aims to provide a systematic approach to health service delivery at all levels in line with these government commitments, including to the MDGs. The EHCP was seen to be one measure to address existing inadequacies in the health sector, including poor coordination and harmonization of health services, inequitable access to care, overburdened tertiary services, poor alignment of resource allocation to need, lack of health guidelines and standards for health service delivery on all levels and in the national referral system.

Dr Magagula explained the development of the EHCP in 2010 following the 2008 Ouagadougou Declaration recommendation for member states to review/develop their EHB. The high priority health conditions and high impact interventions critical for achieving UHC were identified. The EHCP was launched in 2012. A review in 2017 streamlined the EHCP to a minimum package based on priority cost-effective interventions, burden of disease, available resources, maximizing synergies and linkages in service delivery, and taking technical, political and social considerations into account. This revised benefit package is being piloted in 10 facilities. In addition to the aims outlined earlier, the EHCP aimed to improve responsiveness to clients' health needs, and promote a client-oriented delivery approach, rather than simply as a list of services. In this approach a client presents with a problem, while their

other health conditions are attended to, with cost implications for inputs and components of interventions at each level.

He explained the development and costing process for the EHCP, through a desk review and content analysis of official policy and technical documents and consultation with stakeholders, technical professionals, private sector and development partners. The process faced challenges in the lack of adequate evidence and the time for the process and from development (2012) to implementation (2017). He explained the EHCP costing, using MoH accounting information on medicines, supplies, labour, equipment, overheads and using an activity-based costing model to estimate the cost to provide a set of services at a given facility. There were difficulties in this in the number of interventions for individual costings (2 437), the exclusion of lab tests and supplies in the costing and inclusion of medicines were not on the essential medicines list. The estimated per capita expenditure costs for 2012/13 were found to be $24/capita at community level, $24/capita at clinics and public health units; $19/capita in health centers, $27/capita in regional hospitals and $53/capita in national referral hospitals, with the latter costs high due to specialist doctors coming from outside the country.

He outlined the various ways EHCP has been used in budgeting and purchasing services, in guiding the planning of service expansion into new areas, providing the accounting basis, guiding the readiness of health facilities to deliver services and the resources to do this. Dr Magagula outlined the role of the EHCP in monitoring health service and sector performance against its benefits, in terms also of quality of care and health outcomes, if the MoH M&E system monitors EHCP indicators.

Dr Magagula saw as positive approaches, from Swaziland's experiences, their sharing of a policy and strategy on the EHCP to build a common understanding of it at all political & technical levels, including using fora such as the Parliamentary portfolio and ministerial committees to build public awareness of the EHCP.

He also outlined the challenges in the poor fiscal environment; limited resources against high costs of the full EHCP; a high burden of disease; inadequate health infrastructure and logistics for EHCP delivery; and, insufficient qualified staff and incentives to retain and motivate productivity.

He suggested that dialogue on the EHBs in the region need to consider a defined basic package of health services designed to benefit the majority that contribute significantly to reducing the burden of disease in the country that is affordable and for which available resources be directed and invested. He also proposed that cost estimates be regularly reviewed using primary data from facilities and programmes and secondary data from other countries. He stressed that the prioritization of health interventions during early stages of EHCP development is critical, in line with the available resources (financial and personnel) required to implement it, and possible challenges in the health system that could hinder it be addressed. He also noted that the success of EHCP implementation will at the end of the day be determined by the level of political support and public awareness.

In the discussion after the two presentations delegates noted the difficulty with design and implementation of the EHB when the MoH does not have a specific department or focal person for that purpose, particularly given the many units involved in different aspects of the EHB. Delegates thus recommended that ministries assign a focal person / department to advance the EHB in policy, planning, to lead discussions on using the EHB as a tool for purchasing / contracting services, in integrated service delivery and for financing and reporting on health, poverty reduction and social outcomes. They noted there is need for better understanding of EHB and what it can achieve in the long-term.

It was also suggested that tools supporting EHB design and implementation be developed through regional collaboration, particularly for costing the benefit package and to guide in transitioning from minimum towards wider benefit packages that are needed for UHC. Regional collaboration could also usefully share good practice on approaches that are responsive to population needs ad inputs, and that look beyond facility-based interventions to include community and PHC dimensions, including health promotion, prevention and wider sectoral co-operation in public health.

4.4 The EHB in Tanzania Mainland

Dr Oberlin M. E. Kisanga, MoHCDGEC, Tanzania presented the Tanzania mainland case study. (See EQUINET, Discussion Paper No. 109 for full information). He outlined the evolution of EHB in Tanzania: starting from the first Tanzania Essential Health Interventions Package (TEHIP; 1996-2000), through to the 2013 National Essential Health Care Intervention Package (NEHCIP-TZ; 2009-2015). He noted that TEHIP tools continue to be used to this day to prioritise, plan for and respond to the burden of disease. The NEHCIP-TZ conceptually shifts the benefit from 'essential' to 'minimum' health interventions: with 11 strategies defined to improve EHB for a cost close to $9 million. The NEHCIP-TZ is under review, in line with the new HSSP IV (from 2015.). It aims to improve efficiency, equity, political empowerment, accountability and more effective care by guaranteeing and concentrating scarce resources on interventions, which provide the best 'value for money'.

Dr Kisanga observed the value of an EHB as a tool for guiding, organizing and planning quality service delivery, noting that this doesn't always require extra financing, but does require a change of mindset on all levels. The NEHCIP-TZ (2013) design evolved from discussions and inputs from a cross section of stakeholders including government representatives, partners and community members; applying decentralized systems for district planning, implementation and outcomes along with costing and financing; to achieve an integrated (multi-sectoral/ inter-sectoral) approach focused on five service clusters areas (including governance and management reform). It is seen as a guide for service delivery, strategic purchasing and resource allocation. Current discussions are exploring the minimum benefits package (MBP) to address the resource gap (between $9-$178 million) of the wider NEHCIP-TZ, with the MBP focused on a key set of services that citizens are legally entitled to and can freely access at point of care, funded from pooled resources.

Tanzania has systems on all levels for reporting on the progress of EHB from council level health services to central health databases, following expenditure and disease burden to assessments on service availability, readiness and star-rated facilities (quality/standard of care). From the data, assumptions on need and prioritization can be made. The EHB is integrated into council health plans and budgets and serves as a tool to guide service implementation. For the wider EHB its services are 'essential', but not necessarily free. While a more focused package sets the services to be provided free at point of care to address the financial deficit, the ultimate aim is to have a social determinants of health approach including multi-sectorial action within UHC. He observed that this and community voice still need to be reflected in the design.

Dr Kisanga shared good practices from Tanzania's EHB experience in directing meager resources to address equity and establishing a basis for health budget development and for estimating the financing gaps, for mobilizing non-state resources and for defining the MBP as a more focused package provided free at point of care. He observed that the EHB helped people to think 'beyond the traditional box'.

There were also challenges encountered, in the limited fiscal space and dependency on external resources weakening integrated and multi-sectoral financing, in public financial management and quality of health services and in the capacities of local government authority and council health services for complex decentralized services. He stressed that Tanzania's EHB has evolved over time and focuses on service clusters and standards, as well as management reforms and plans for implementation. However, even though it sets policy priorities, people need to be realistic on what EHB can offer, particularly if we fail to identify innovative means to generate revenue to financing the health sector.

From Tanzania's experience, he recommended that the EHB be applied and adapted as a means for UHC, backed by advocacy for health to be included in all sector policies as a pre-requisite for regional development including industrialization. He recommended strengthening decentralized health SWAps as a sustainable strategy, and greater community involvement. For the technical design Dr Kisanga recommended, as in other country reports, regularly updating the interventions and costings to contain/ensure equitable access, keeping a balance between health promotion/prevention and curative services, and between primary, secondary and specialist services.

Tanzanian delegates described their SWAp joint task force of government (health, PO-RALG, finance, community development), the DP Group, private sector, and civil society members who plan and

disburse basket funds towards those plans. The joint task force has technical, management, financial and monitoring functions with SWAps. While individual funders do support specific interventions, vertical programmes or geographical areas, fragmenting resources and services, by involving the community and health facilities, they may find resources to sustain the projects, after external funding ends.

In the discussion, delegates elaborated further on the role and contribution of other sectors in public health, such as through the key role school health plays, not well tapped during the AIDS epidemic, but now a greater focus of joint health worker, teacher and community member planning. The addition in Tanzania of community development, gender, elderly and children to the health ministry remit was noted, with five strategies, 21 strategic interventions, and 11 Technical Working Groups consisting of members from all sectors in the new health strategy. Various inter-sectoral collaborative mechanisms were raised at national and local level, involving also civil society and private sector, while noting that they need systems for other sectors to be accountable and to report on health outcomes.

4.5 National Health Insurance in South Africa: The Road to UHC

Dr Themba L Moeti, Executive Director, Health Systems Trust, South Africa gave a brief overview of the context for the new plans for the National Health Insurance (NHI) in South Africa, including its upper middle income status, 55.9 million people and progress made in the 23 years since apartheid in education, health, housing and economic opportunities, but with huge social disparities and high levels of poverty. This means social determinants influence access to and coverage of quality health services for UHC and health outcomes. In the health sector there are disparities in health expenditure and health worker distribution between public and private sectors, overburdened public health facilities and challenges to quality of public sector services related to medicine supply chain management, aging infrastructure and shortage of personnel. Private health care is among the most expensive globally and is subsidized by government through medical aid schemes for its employees and state-owned enterprises. Of the 8.5% of GDP spent on health, 4.4% (52% of total) is spent in the private sector servicing 16% of the population; while 4.1% (48% of total) is spent in the public-sector servicing 84% of the population, leading to inequities and poor health outcomes relative to health spending.

The National Health Insurance (NHI) was thus established to

- Address inequities in funding of and access to health services.
- Transform the current health system from an under-resourced public health system accessed by majority of the country's poor and private health care funded by voluntary contributions accessed by the privileged few to a unified health system for all.
- Pool health financing for universal access to quality health services.
- Ensure sustainable, equitable access and UHC through a more cost-effective PHC-oriented health system.
- Provide financial protection when accessing health care, prioritizing the most vulnerable.

The legal and policy framework for the development and establishment of NHI into a unified health system is found in the Constitution (Section 27), which gives citizens the right to access quality health care services delivered equitably, affordably, efficiently, effectively based on social solidarity, equity and health as a public good; the 1997 White Paper on transforming the health system; Vision 2030 and the SDGs; the 2011 NHI Green Paper for the pilot phase and 2017 NHI White Paper for Phases 2 and 3.

The NHI is being implemented over 3-phases within 14 years. Phase 1 (pilot) began in 2012 with health system strengthening initiatives implemented in 11 NHI pilot districts until 2017/2018 as below:

- An ideal clinic initiative to improve service quality in PHC facilities using a dashboard tool.
- A PHC re-engineering initiative to strengthen PHC delivery through ward-based outreach teams, an integrated school health programme, district clinical specialist teams and contracting PHC providers.
- Establishment of an Office of Health Standards Compliance for quality service delivery standards.
- A central chronic medicines dispensing and distribution system to improve medicine availability.
- An electronic health patient registration system based on unique identifier.
- Reforms to strengthen the national health laboratory service.
- Health technology deployment to improve service quality and access.

In NHI's Phase 2 (2017/18 – 2020/21) action will be taken to:

- Finalize legislative frameworks for NHI and related laws and establish the NHI Fund and its institutional/governance structures.
- Certify health establishments by Office of Health Standards Compliance and certify, accredit and contract health service providers and public hospitals.
- Mobilize additional NHI funding from taxes and dedicated taxes for higher income earners.

He briefly described the eligibility for and benefits of the NHI. NHI will offer all the country's legal residents access to a defined package of comprehensive health care services from primary to tertiary and quaternary levels. The benefits include preventive, promotive, curative and rehabilitative services in PHC facilities, hospitals and emergency medical care (as shown in *Figure 2*).

Figure 2 South Africa's National Health Insurance Benefits

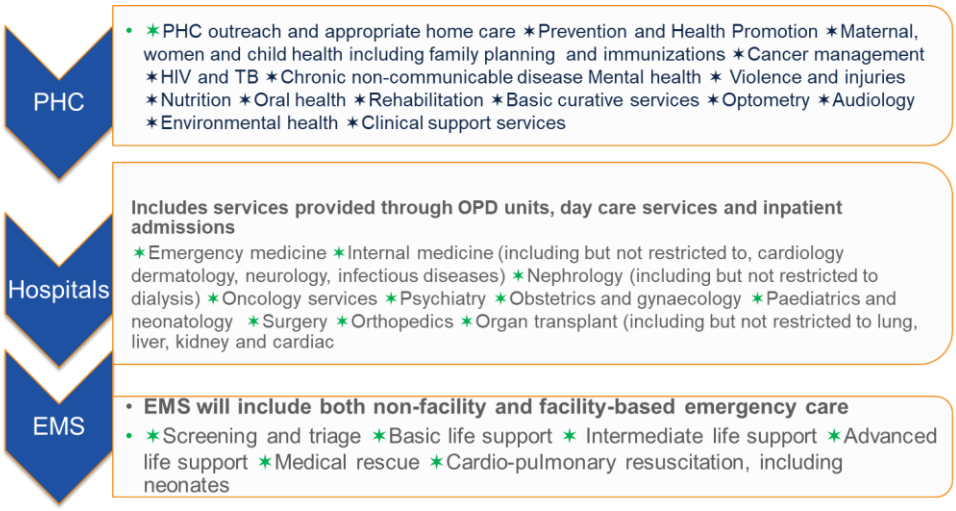
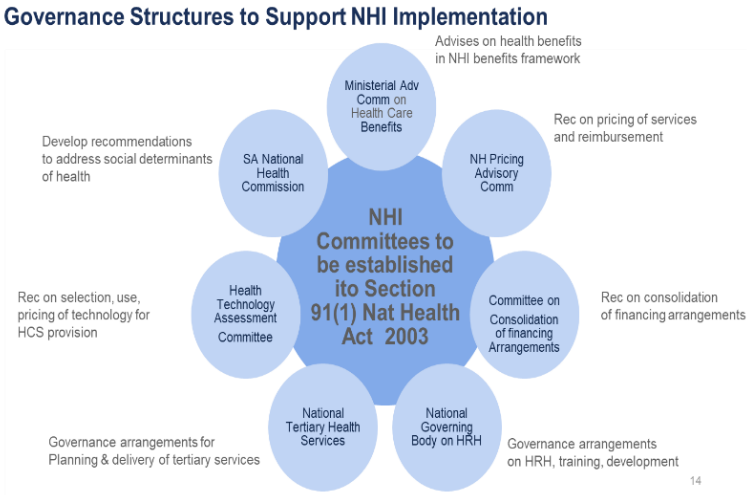


Figure 3 Committees Governing NHI



He outlined the various committees being established to transform the health system and govern NHI implementation with a brief overview of their functions (Shown on *Figure 3*). Of relevance to the EHB the Ministerial Committee on healthcare benefits advises on the benefits, the Pricing Advisory Committee on cost of services and reimbursement and the National Health Commission addresses the social determinants of health.

While the NHI aims to ensure a well-functioning health system with a strong focus on PHC and a financing system of pooled funds from public and private sectors for equitable and universal access to health care by 2030, various challenges are being encountered in the implementation, including:

- Resistance from those seeking to protect their own interests and to the management reforms;
- Difficulties in building trust and collaborative networks between public and private systems;
- Obtaining the financing required for health investment during low economic growth.
- Overcoming the dominance of a costly curative, private health care model
- Addressing the low coverage of South Africans by insurance schemes (8.8 million of 56 million).

The priorities for the NHI from 2017 onwards thus relate to utilizing available resources in both private and public sectors to progressively expand the service package financed by the NHI Fund. There is strong government commitment to move forward on this and implementation through a PHC approach, building on lessons learned during the pilot phase and from research. Priority will be given to populations in greatest need and vulnerable groups, including learners (school health), maternal and women's health, those with mental illness, elderly people and people with disabilities.

5. Positive approaches and challenges from country experiences

5.1 Plenary discussion: What role for EHB in advancing UHC?

Halima Abdulla, Deputy PS, MoH, Zanzibar started the session with a brief overview of Zanzibar's EHB. She stated that in the Constitution and health policy, healthcare is free for all. Zanzibar has many foreign volunteer professionals providing specialist services for free. Cost-sharing was suggested at one time after conducting studies, including on client acceptability, but the government did not allow it and seeks to fund MoH bids in full. While services are in policy free at point of care, in practice declining government budgets mean that they are not.

Dr. S.V. Magagula, MoH, Swaziland chaired the plenary discussions on the issues raised from the across country case studies for the role of an EHB in advancing towards UHC. Delegates commented that various areas need to be addressed in a combined manner for UHC and not as stand-alone issues:

a. *Willingness to invest in UHC.* Most health system funding models are based on taxation, which is sustainable, but rising costs of commodities and operations is constraining investment in priority areas of the EHB. Countries are thus struggling to fill the funding gap through cost-sharing, pre-payment, health insurance schemes with varying results. If free access to quality services at the point of care is the aim of UHC, then governments must pursue other financing mechanisms to invest in a health system that can deliver UHC, such as through wider progressive, dedicated taxes. The over 60 year experience of the UK-National Health Service was cited as one example of how fair and equitable access to social services for all can be supported by taxation, even while it faces current challenges from austerity cutbacks. The resources also need to be provided for the incentives, training and effective supply of health workers.This raises political choices: Healthcare and UHC is only as free as taxation allows, and can governments afford *not* to invest in health – and an EHB – given the implications of increasing costs to the government, population and economy from rising mortality, morbidity and lost productivity?

b. *For UHC to be operationalized, people need to understand and champion the EHB.* People need understand that they've already paid for services through taxes or insurance, shouldn't be paying at point of care and should know what they're entitled to. For effective planning, the population needs to be known in each catchment area, such as through enrolment/ registration of all covered by services.

c. *The primary care level is fundamental* for entry into the EHB system and as point of care. Given scarce resources, the primary care level is the most pro-poor level of the health system and should be the priority for public funding and health worker investment and not reliant on unpredictable external funding.

d. *Common systems can be used for costing and price monitoring for the EHB,* including what to cost and what costs to control, particularly for private sector and insurance, where without price monitoring costs can escalate.

e. *Value for money is important in any criteria for selecting benefits included and covers wider concerns than cost-effectiveness.* In identifying priority interventions for the EHB, value for money looks at the health gain; quality and efficiency; client-satisfaction; cost –benefit, and potential for control of cost escalation. These factors all need to be considered in making the rationing choices of what priority services people are entitled to and health workers are expected to provide.

Following this plenary discussion delegates divided into two groups to discuss the lessons learned from the country work on the positive approaches and challenges in:

i. The methods used to develop/define and cost the EHB, and to involve/disseminate/communicate EHB to key health stakeholders
ii. Implementing the EHB within countries, for budgeting, resourcing and purchasing health services and monitoring health system performance for accountability

5.2 Group discussions: Positive practices and challenges in designing the EHB

This discussion covered the design, costing and dissemination of the EHB. The issues raised by the group are shown in *Table 1* below:

Table 1: Positive practices and challenges in design, costing and dissemination of the EHB

Area	Positive practices	Challenges
Designing the EHB	• Consulting with multidisciplinary stakeholders from state, sectors, civil society, private sector at the design stage to facilitate dissemination, • Lobbying the Head of state for EHB support, and not only health and finance ministries.	• Bridging the gap between an aspirational and actual package, beyond curative care only to include curative, promotive, preventive, rehabilitative, emerging, re-emerging conditions and epidemics • Harmonizing the EHB with divergent stakeholder interests and national/international commitments can limit EHB progress. • Inadequate understanding amongst stakeholders of the EHB process and purpose limiting buy-in • Poor political/stakeholder input at the design stage limiting support for the EHB once complete.
Costing the EHB	• Using evidence-based processes with accurate, up-to-date information from an efficient health information system covering health facilities, community and private sector. • Costing on a per capita/per level of care basis and including in-service training costs.	• The length of the process and specialized skills and accurate, valid primary data required. • Use of assumptions for cost and quantity in costings that if not valid, can result in inaccurate estimates and compromise the package.
Disseminating the EHB	• Using existing country systems, with village health committees, community health workers, religious leaders and political platforms. • For all stakeholders in the design process to participate in dissemination.	• Difficulties in reaching groups that perceive their interests to be poorly considered. • How to include all groups and translate the package into all main local languages to ensure awareness and understanding of the EHB.

In the plenary discussion, delegates concurred on briefing the Head of State, as well as parliament, its health committee, including for the budget allocations. Consistent, regular interactions with this committee can take up health issues and NEAPACOH, an umbrella association of parliamentary committees on health in Africa meets regularly to share information on health and common issues, as well as regional parliamentary committees in SADC and ECSA.

Involving the community in the EHB design process was noted to be useful, but technical meetings can be intimidating and disempowering for the community. Their engagement can also come through on-going community engagement in participatory processes through health committees, community groups, health workers for them to input their priorities and to build understanding of the EHB. The EHB process should be embedded in existing community activities such as training village health committees, literacy and dialogue so it is not seen as a one-off event. This will also build relationships and trust, and enable more realistic community expectations and shared responsibility in the results. Delegates also saw it to be important to consult with communities and council management in how best to implement EHB, such as for local decisions on infrastructure and the investment needed for renovation or new construction.

5.3 Group discussions: Positive practices and challenges in EHB implementation

This discussion covered implementation of the EHB, and its use in budgeting, resourcing and purchasing health services and in monitoring health system performance for accountability.

The issues raised by the group are shown in *Table 2* overleaf:

Table 2: Positive practices and challenges in implementing the EHB

Area	Positive practices	Challenges
Implementing the EHB	• A conducive institutional framework, with a clear health policy and strategic plan. • Functional SWAp arrangements. • An integrated, holistic approach to services, with appropriate guidelines linked to quality of care standards. • Strategies and interventions linking health to poverty reduction. • A dedicated EHB department/focal person in the ministry. • A functional information system for data collection, planning, monitoring and assessment of value for money. • Multisectoral participatory design and implementation arrangements, with community involvement and responsibility. • Presence of political will and leadership from the highest levels (head of state) and including related ministries and non-state actors.	• A weak governance and institutional framework leading to problems in technical decisions on the EHB and the level of provision. • Poorly defined contractual agreements for strategic purchasing. • Inadequate readiness of facilities to provide EHB in terms of health workers, equipment, infrastructure, client/ provider ratio and skills. • Weak regulatory framework to monitor quality services in public and private sectors. • Inadequate social literacy and understanding of EHB. • Financing gaps in the public sector. • Inadequate regional cooperation and joint approaches in addressing common EHB issues, such as health worker production and retention.

In the plenary discussion, the financing gap was explored, relating mostly to public sector underfunding, but also unpredictable and poorly aligned external and private financing and off budget financing. Delegates noted that the resource mapping and national health accounts exercises underway in some countries help to align resources towards health goals, as they identify those who contribute finances towards meeting health plans annually. It was noted that they need to capture off-budget contributors.

6. Regional learning and cooperation on EHBs

Chaired by *Sue Godt, IDRC Canada,* through two presentations, this session synthesised the learning from across the research programme as a whole on the aims, design and implementation of EHBs in ESA countries. The presentations drew on a synthesis paper prepared as a draft by TARSC and IHI, with input from the regional literature review and case studies, and that would be finalized as a joint product of the regional and country researchers after the meeting. (Full information is provided in the synthesis paper, EQUINET discussion paper 113).

6.1 Context, policy motivations, design and costing of EHB in ESA

Masuma Mamdani, IHI/EQUINET noted as a *context* for the EHBs that ESA countries face similar pressures (global, regional, national) to protect high shares of vulnerable people from impoverishment due to ill health. The right to health care is in the constitution of seven ESA countries and further elaborated in its health laws. But with the structural adjustment in the 1990's, countries had to prioritise health interventions based on available scarce resources, particularly on MCH services given the MDGs. The 2008 Ouagadougou Declaration on PHC raised the profile of EHBs for universality and equity. ESA countries have widely ranging life expectancies (47-73 years) and prevailing inequalities in health outcomes by wealth, geography and other social factors. While there have been some improvements in maternal, neonatal, infant and child mortality generally, many countries continue to fall short of their health goals and new challenges from rising NCD levels and emerging diseases. Many countries are making slow progress in meeting the Abuja commitment of 15% government financing, and resource challenges in all have implications for equity, sustainability and integration of services. This is aggravated by a dependency on external financing and a high level of out-of-pocket spending, rising health care costs and increasing cost burdens on households. There is increasing attention to linking resources to performance based financing (PBF) initiatives for selected services.

Most ESA countries have an extensive and interacting network of public sector health services at community, primary care, secondary, tertiary and quaternary levels, complemented by private not-for-profit (faith-based and NGO) and private for-profit services of varying size across the countries. They have varying levels of decentralization of administration of services and programmes that apply promotive, preventive, curative and rehabilitative services to key health challenges. They have mechanisms for coordination with stakeholders and health sector partners, but with varying influence on resources and service providers.

Within this context, the *motivations/purpose for EHB* from the case studies indicate its role in:

- Clarifying universal entitlements set in law and policy as part of national strategic plans.
- Resource allocation to prioritized health services, based on the burden of disease.
- Costing prioritized services and clarifying infrastructure and health worker capacity gaps.
- Fostering coordination in planning, budgeting and implementation of services across various providers at all levels of the healthcare system.
- Supporting decentralization, integrating the EHB in local government planning and with communities.
- Protecting against impoverishment due to ill health and high healthcare costs.
- Building trust between citizens and state.

Regarding *EHB design methods and processes*, there was evidence of variation in the approach to define benefits or priorities in the region. In most countries, the process was initiated and designed by MoHs; in some instances, by international funders. Each country's design process was guided by national development and health policies, with an integrated package of cost-effective interventions addressing the burden of disease, backed by protocols and service standards and stakeholder feedback. Countries applied various criteria to prioritise services included, including equity, value for money, cost effectiveness, capacity to deliver services at each level, social determinants and public health (Tz), impact on poverty reduction (Ug), long-term survival and quality of life (Zambia) and client responsiveness (SD) of interventions.

For most countries, *consultation* was part of EHB development, but varied on who was involved and at which stage of the process. All case study countries involved government, private, non-state, technical and international agencies, while some involved other ministries, external funders and stakeholders. She explained how stakeholder involvement in the EHB design process has implications for ensuring ownership and dissemination. Some countries have provided training and communication for stakeholders at different level, and others include community evidence in national BoD assessments. The EHB was largely applied in the public sector, although intended for the private sector in five ESA countries. The prioritised services were defined at primary care level in all countries and at hospital level in most. The case studies highlighted how the benefit package evolves over time, affecting the content, and scope of coverage, with some starting as pilots before rolling out nationally.

From the research, she raised issues for further consideration *in the design of the EHB* as:

- Keeping it as a holistic tool to strengthen health systems, including with other sectors to address the social determinants of health.
- Addressing current and longer-term health burdens, as feasible given capacities and resources.
- In technical and policy decisions on the EHB involving key stakeholders, including local health providers and communities, with formal adoption by the cabinet and Parliament.
- Applying it to public and private sector services, and at all level as a support to decentralization.

She outlined the diverse methods used for *costing the EHB*, their use of various sources of data, including from national health accounts and the health information system and facility expenditure data at different levels to quantify and costing inputs to deliver the EHB interventions, generally in public and private not-for-profit sectors. The methods and assumptions used for both prioritization of services or

Table 3 EHB Cost Estimates for Select ESA Countries

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 health care across levels $28.6/capita for EHP healthcare	2004 2007/8
South Africa	$31/capita $111-$272/capita	1998 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

their costing were not always clear, or comparable across the region. *Table 3* shows these *cost estimates* from the regional review, indicating wide variations in unit costs at each level and in total per capita cost, from $4-$25/capita for primary level service to $13-$272/capita for all services, compared to a basic per capita cost estimated by WHO in 2008 to be $60/capita. The research highlighted the importance of differentiating on these costs by sector (public and private) and level of care. She highlighted also how the assumptions affected the costings, including: assuming service costs were the same across public and private health facilities; that referral facilities received patients who had been treated at lower level facilities; underestimating real system costs of providing services; not taking into account vertical and off-budget support to the health system; and, not accounting for variations in unit costs between districts, levels of care and providers.

She highlighted issues to consider in future EHB costing as:

- Updating EHB costings periodically, possibly in line with timings of sector strategic planning?
- Clearly documenting guidelines for and sharing the methods, assumptions and limitations in costings regionally, including to obtain peer review of the assumptions and calculations.
- Building regional exchange on guidance on methods and assumptions, capturing costings applied in different countries and setting up a regional price database to support costing exercises.
- Addressing significant data gaps on costs in the private-for-profit sector, including private financing and insurance arrangements..

In the discussion that followed delegates raised concern about variations between national and international data for the sector, arising in part due to the use of assumptions in the analysis not used by countries. It was noted that international and regional data needs to use standardized approaches and definitions to make comparisons across the region, so where there is variation with national data, both may be reported with explanations for the differences. At the same time it was raised that regional and international databased should seek to use validated national data for regional comparisons.

Delegates also remarked that health information systems aren't collecting data needed to reflect changes in the EHB agenda, such as health promotion, prevention, quality of life, quality of services, satisfaction surveys and lifestyle. Countries may consult international databases for this raising the need for regional evidence. It was noted that ECSA HC is providing this on its website and that the issue could be taken up at WHO regional meeting discussions on data systems.

6.2 Implementing EHBs in ESA: Regional learning and policy issues

Dr Rene Loewenson, TARSC/EQUINET drew further from the draft synthesis report to review what has been achieved, the factors affecting implementation, lessons learned and policy issues arising from EHB implementation. She reminded delegates of motivations for the EHB, based on:

- *Rights* to clarify public, sometimes legal entitlements from all providers.
- *Policy commitments* to PHC, equity, UHC and to promote health, reduce priority diseases, extend coverage and advance health equity and universal care.
- *Financing concerns* to negotiate, coordinate and direct scares resources to purchase prioritized cost-effective services provided free at point of care (insured or public funded)
- *Efficiency, public accountability and trust* to coordinate planning, support centralization, monitor delivery, service performance and quality and build trust between citizens and state.

The research showed how the EHB has been advanced within national health policies, strategies, SWAps, and discussions on insurance and incorporated into local government planning and budgets. It has led to the development of guidelines for quality and services standards, staffing, service readiness and infrastructure norms. At the same time it has had more limited use in budget negotiations and contracting/purchasing of services (particularly in private, non-profit sectors) and in performance monitoring, which needs a strong HIS for proper monitoring.

While EHB implementation has been affected by wider system issues, some constraints are specific to EHB, including the fact that the disease burden outstrips available scarce resources and capacities required for the services to address it, and gaps in communication, management and operational guidance and supervision of the EHB. In the wider health system, weaknesses in the health information system; falling public revenue and health funding; fragmented, unpredictable financing; vertical programmes which limit service integration; staff shortages, maldistribution, performance/productivity

gaps; and inadequate political 'buy-in' of EHB have affected its implementation. However these challenges are what EHB is supposed to address! She asked delegates to what extent EHB can be an effective lever to address these wider system constraints.

The research showed that understanding of the EHB and its potential role in strengthening the health system is enhanced when: stakeholders were included/consulted in the design phase; when the EHB is included in health strategy documents and in ministerial, strategic review, policy and planning annual, biannual and monthly meetings; and used in management, purchasing and monitoring services; communicated in guidance to local government level; disseminated in public media and campaigns; and, is a responsibility of a specific government department. But these factors are not always present, especially at local health system and community level. The research highlighted that EHB monitoring is enhanced when: there is investment in the health information system as the main resource for monitoring, complemented by facility and household surveys and linked to improvements, meeting gaps, sector reviews, and reported publicly, to stakeholders and to parliament.

One of the untapped potential areas of use is in financing and purchasing, to undertake gap analysis to identify and cost capacity gaps, ensure capacities (facility pre-requisites) are in place to use recurrent resources effectively; ensure relevant support tools for budget setting at local level, with secure sources of resources linked to EHB vote functions; as a lever for pooling of diverse funding sources (within a UHC framework, i.e., SWAps, NHI), linked to performance contracts and monitoring. The costing of an EHB, if credible, can be used to show the cost demands of prioritised services, to negotiate improved allocations to health from tax financing, align external funds and private financing and promote innovative financing to meet gaps.

The research indicated that some countries have addressed the resource gap by limiting the benefits in a 'minimum package', but given the commitment to UHC, she asked delegates to consider how minimum and focused packages transition into the comprehensive EHB needed for UHC? She pointed for example to the fact that investing now in areas of rising disease burdens such as NCDs may seem costly, but can make significant savings in future high heath service, household and economic cost burden, showing evidence from trends to 2030 in these costs from NCDs in Zimbabwe as an example.

She noted issues raised in the research to support operationalizing the EHB, including standardising or clarifying methods, assumptions and decision-making criteria used to prioritize services, setting up a working group for peer review and for periodic review of the benefits and costs, potentially aligned to strategic plans and supported by regional databases on pricings and costing methods. The research showed that EHB implementation is supported by formal inclusion in development plans and health strategies, and by consultative and dialogue processes for its development that build awareness and ownership. It is also supported by service guidelines; methods for gap analysis of service readiness against EHB standards; specific vote lines for EHB services for financial appropriation; its use in setting budgets and performance financing and in purchasing contracts with non-state services.

The case study findings highlighted the potential of the EHB to operationalize PHC, UHC, equity policies and strategies, to respond to demands for client-centered services for a changing population health profile and to provide a measure to support policy alignment, coordination and overcome fragmentation. It provides a standard to clarify capacity gaps, resource demands for allocative efficiency, a poverty reducing measure, clarifying services for financial protection and a standard to guide decentralization and accountability on service performance and funding. It can thus contribute to trust between citizens and state on their respective rights and duties. To realise this potential, she noted that the range of challenges already raised in the case study and the two synthesis presentations need to be addressed.

She noted that taking the policy dialogue on the EHB forward would need to align where it has potential to the different interests and priorities of different policy stakeholders. Delegates noted for example that political actors may be interested more in its role in clarifying constitutional rights and policy entitlements and supporting public accountability on service performance, economic actors may be more interested in its potential to align resources to value for money interventions that have greatest impact on the disease burden, and its ability to guide resource allocation to meet capacity, skills and financing gaps, while

service personnel may be more interested in its role in promoting holistic care models and guiding treatment models.

Dr Loewenson outlined key issues for future policy dialogue:

- On the criteria used to prioritise services included to address equity and universality;
- Whether given resource constraints to focus resources on a wider package in primary level or limit services across levels;
- How to avoid the minimum becoming the maximum? What triggers, criteria and trajectory to expand it over time; and widen to the private sector.

She noted that while the issues raised are wide ranging, the research suggests that the EHB provides an important system tool and lever to operationalize the commitment to UHC, to fairly and effectively set service priorities, to clarify gaps and review and support service capacities, to engage and align non-state and external funders and providers on national priorities for UHC, and to involve, inform and be accountable to key stakeholders and the public in these processes.

Delegates discussed the two presentations. They raised that a major issues to address to realise the EHB potential in UHC is *effective and equitable financing.* It was agreed that taxation is the most progressive, equitable form of financing that provides financial protection. Delegates were concerned that social health insurance and private insurance, often promoted to meet funding gaps, are not the only solution in bridging financing of EHBs and may be more inequitable than forms of wealth taxes. They suggested that ministries of finance be challenged to exhaust taxation options before collecting revenue through less progressive options, such as segmented insurance. Delegates also saw taxes as a key means to lever private sector contributions to sustain EHB. Delegates saw as useful economic studies that raise both health care and indirect (economic, sectoral and household costs of not providing key health services) and suggested these be implemented to quantify the lost labour, employment, savings and production income and increasing poverty and vulnerability from not addressing rising conditions such as NCDs. It would be important for such studies to show what services would reduce the burden of disease and these costs, and where resources for these services may be sourced from.

At the same time, delegates noted that this calls for a different understanding of health and health interventions as a contributor to development. They noted that the *EHB can be used to incorporate health into National Development Plans,* but that for this there is need to build a wider link to the role of other ministries and sectors in health, and brought to inter-ministerial and multi-sectoral collaboration forums to discuss the roles, links and resource arrangements for it.

Delegates suggested that for this, the EHB should e*mbed and account for health interventions in other sectors*. In addition to health sector's EHB package, the prioritised role of other sectors in health should be stipulated in their policies, operationalised and financed (i.e., water, education, infrastructure) to support national health goals. The health sector can assist in guiding the process with other sectors, to put health into policies, develop systems for monitoring implementation and outcomes. While this was noted to be a challenge in economies that build inequalities in wealth, emerging epidemics and disaster situations raise an opportunity to bring sectors together to embed health into their policies and practices.

7. Recommendations for policy dialogue

Following these country and regional inputs, delegates discussed in groups their **recommendations on how to advance the work on their EHBs particularly given its potential as raised in the meeting as an entry point for or measure supporting UHC and integrated, universal and equitable health systems.** One group explored this at national level and one at regional level. Both discussed areas for further research for achieving these goals. The two groups presented their recommendations for plenary discussions, as summarized below.

7.1 Recommendations for national policy dialogue on EHB

The meeting recommended the following for *national EHB processes*:

a. *Everyone is entitled to EHB*. Everyone must contribute to it according to their needs and ability; in the long run, universal benefits for all needs a broad tax base and EHB can be the start of that process.

b. *The EHB must be financed*. Availability of financing will promote EHB implementation, bringing UHC closer. Private sector resources must contribute to this, to pool resources for cross-subsidies for universal provision of the EHB, and the methods for this need to be explored. Pooling of funding for the EHB could be strengthened through integrating earmarked programme funding into pooled (eg SWAp) funds and legislating mandatory contributions and/or progressive taxation earmarked for it, with measures to protect poor households.
c. *The EHB should promote a multi-sectoral approach to health*. It should link relevant sectors early in the design process, preferably coordinated by a higher ministry (President's or Prime Minister's office), as a starting point for other sectors to respond at policy, implementation and local levels. It implies defining how other sectors' (water, sanitation, school health) can contribute to health and linking their interventions to the EHB to address and monitor action on priority social determinants of health as a contributor to public health, socio-economic development and disaster management/mitigation.
d. *The EHB should provide holistic, quality health services* from community, to PHC level upwards. It should include resources for all services (preventive, promotive, palliative, rehabilitation), not just treatment; and address health worker performance issues affecting service quality and productivity.
e. Link *EHB monitoring* to existing performance or information systems and use the EHB as a tool to monitor performance and social determinants, and the contribution of the EHB to key policy goals such as equity, service and health outcomes.

In the discussion a key question was *who will take the lead to move the EHB agenda forward nationally*. Decision-makers know about EHB, but the movement is not happening from meetings in country and the region with health and finance ministers. Champions have informed and influenced decision-makers, but are they in a position to enact recommendations from this meeting? It was also proposed that *research provide* a better understanding on how financing, service delivery, performance gaps have been (or can be) filled from the experience of other countries, what tools can be used for effective dissemination of findings; and how to identify and reach the most vulnerable with the EHB services.

7.2 Recommendations for regional policy dialogue on the EHB

The meeting recommended *regional cooperation* to support key areas of work on the EHB, by

a. Setting up a regional repository for information and knowledge-sharing on EHBs;
b. Providing good practice exchanges to inform EHB movement, including sharing documents and visits and reporting on progress in addressing design, costing and operational challenges in forums such as the ECSA HC Best Practices Forum.
c. Developing a regional guidance document on EHB design, costing methods, operational issues, with links to resources and institutions, and links to a regional pool of multi-sectoral EHB expertise, including on costing the EHBs.
d. Setting up a database (eg at ECSA HC) of commodity prices for equipment, medicines and commodities to support national EHB costing exercises linked with other existing regional databases, such as on medicine prices.
e. Integrating the EHB into training for and negotiations in global health diplomacy, given the policy and practical issues it raises for achieving UHC .

The group recommended that various regional platforms be used to disseminate updated information and raise policy, scientific and public awareness on EHBs and their potential, including the ECSA HC Directors Joint consultative conference; the regional associations of parliamentary committees on health; regional health conferences and global symposia. They also noted the need for regional training to build the health personnel capacities and overcome the staff and skills gaps needed to deliver EHB. They suggested that it would be important to improve coordination between the different regional networks and fora to avoid duplication and strengthen dialogue with key decision-making platforms, such as the African Union, SADC, ECSA on EHB and other health issues.

While many of the knowledge gaps call for country level research, it was proposed that a regional framework that brings countries together to implement joint research and exchange findings would be useful to explore the role of the private sector and the community in the EHB from design through implementation, and how to transition current 'minimum' packages to comprehensive packages as part of long-term planning.

8. Moving forward: Future work and closing

Rene Loewenson, TARSC/EQUINET summarized the key recommendations, take home policy messages and follow-up to be done at national and regional levels after this meeting and led discussions on next steps in moving EHB forward.

Members agreed to the importance of *organizing and disseminating information from this meeting*, as a process and not an event, depending on the country context and considering strategic entry points and policy issues to raise in that country. Messages should be ready to pass on to influential actors when opportunities arise. Delegates saw it as necessary to brief the permanent secretary, minister and possibly cabinet on the recommendations, and for the evidence and proposals on the EHB to be taken up with other 'champions' and for a, such as in the health sector review processes. A means of tracking EHB progress should also be devised.

This includes taking the concept to other sectors. The meeting had raised, noted earlier, missed opportunities for *multi-sectoral collaboration* to provide services for all age groups to reach the most vulnerable not covered by insurance or services, and that strategies are needed to reach other sectors who have a role in providing EHB (army, water, education and so on), nationally and regionally.

It was raised that while the country personnel would receive the meeting report and the synthesis paper from EQUINET and a policy brief to support their engagement at national level, at regional level the next ECSA HC DJCC and Best Practices Forum may be a good opportunity to share the learning on EHBs, while at global level a session may be submitted for the next Health System Global symposium in 2018.

In the closing, *Halima Abdulla, MoH, Zanzibar* remarked how minds have been opened over the past few days from the presentations on EHB. She indicated that she would pass the information on to per permanent secretary who is very interested in this subject area. Many issues were discussed and she appreciated the next steps for moving EHB forward.

Masuma Mamdani, IHI/EQUINET thanked everyone and remarked this meeting has been a huge learning experience, at country and regional level. She thanked all for their contributions and being part of the process, and Rene for her overall technical support and moving the EHB agenda forward at the regional level, and Sue for her continued support through IDRC.

Dr A Nswilla PO-RALG, Tanzania provided closing remarks and appreciated all those contributing to organizing and facilitating this meeting, particularly colleagues from other countries and the attending Deputy PS, Zanzibar. She noted that as technocrats, a lot has been shared and a lot has been learned about each other's countries and EHB. Now the message is clear and we have the responsibility to disseminate this information for EHB to move forward. For Tanzania, this information will be taken to the Deputy PS, PS and Minister at PO-RALG, and to the health sector financing discussions now in progress.

She described health as an industry that is usually focused on the short-term curative care rather than putting investment into preventive care, which has long-term benefits for people and the country. These long-term results/benefits can be calculated and needs to be available to decision-makers to consider for policy development. Once the policy has been formulated, local government will interpret the policy and put it into practice. Monitoring tools must be in place to see how EHB is progressing.

She thanked the organizers and the writers who still have work to be done and take steps to disseminate this information to others in the region and internationally. She appreciated all participants and their contributions and bid them to remember each other when once back home and keep good memories of Zanzibar and its Swahili culture/ heritage. She welcomed all to return to Tanzania, particularly to the capital Dodoma and wished all a safe journey - safari njema.

Appendix 1: Programme

DAY ONE – Monday 27 November 2017

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800-0830	Registration	Registration and administration.	P Mlay IHI
OPENING SESSION Chair Ms M Mamdani, IHI			
08.30-09.30	Opening ECSA HC Welcome Introductions EQUINET intro, Objectives	Opening remarks setting the policy and health system context for the EHB in ESA Welcome remarks Welcome remarks Delegate introductions Overview of EQUINET; Meeting objectives and adoption of the agenda	Prof Y Dambisya Director Gen ECSA HC Dr O Kisanga, MoH Tanzania Dr A Abdulla, Perm Sec, MoH Zanzibar Delegates Ms M Mamdani, IHI
09.30-10.00	The framework guiding the research on the EHB in ESA	Motivations for and analytic framework for the research, issues arising from the regional literature review Discussion	Dr R Loewenson TARSC
10.00-10.30	**TEA**		All
COUNTRY EXPERIENCES OF ESSENTIAL HEALTH BENEFITS Chair: Dr A Nswilla, PORALG, Tanzania			
10.30-11.10	A case study of the Uganda National Minimum Healthcare Package	Presentation of key features of the Uganda case study, issues and policy recommendations Discussion	Dr I Kadowa MoH Uganda
11.10-11.50	A case study of the role of an EHB in integrated health services in Zambia	Presentation of key features of the Zambia case study, issues and policy recommendations Discussion	Mr M Palale, Tamunda Associates Zambia
11.50-12.30	Learning from the Essential Health Care Package in Swaziland	Presentation of key features of the Swaziland case study, issues and policy recommendations Discussion	Dr S Magagula, MoH Swaziland
12.30-13.45	**LUNCH**		
COUNTRY EXPERIENCES OF ESSENTIAL HEALTH BENEFITS, continued Chair: Dr S Magagula, Swaziland			
13.45-14.25	A case study of the Essential Health Benefit in Tanzania Mainland	Presentation of key features of the Tanzania case study, issues and policy recommendations Discussion	Dr O Kisanga, MoH & Dr A Nswilla, PORALG Tanzania
14.25-15.45	Panel discussants on the lens from other ESA countries	Presentation of the South Africa lens on the relevance of an EHB in setting the entitlements to quality primary care and referral services in a context of National health insurance for UHC Discussant: What role for an EHB in advancing UHC? Discussion	Dr T Moeti, Health System Trust, South Africa Dr A Abdulla, Perm Sec, MoH Zanzibar
15.45-16.00	**TEA**		All
16.00-17.00	Working groups	Working groups on key challenges and key positive approaches on EHBs from country experiences. **Group 1:** What 'take home' challenges and positive approaches from the country work on the methods used to develop, define and cost the EHB, and to involve, disseminate to and communicate them to the key health stakeholders **Group 2:** What 'take home' challenges and positive approaches from the country work on implementing the EHBs within countries, for budgeting, resourcing and purchasing health services and monitoring health system performance for accountability	Dr R Loewenson, TARSC/EQUINET Group 1 Chair: M Palale, Tamunda Associates Zambia Group 2 chair: Prof Y Dambisya, ECSA HC
17.00	**END OF DAY**		

DAY TWO– Tuesday 28 November 2017

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800am	Administration	Administration, tickets, transfers.	IHI, P Mlay
RECAP OF COUNTRY EXPERIENCES OF ESSENTIAL HEALTH BENEFITS Chair: Dr I Kadowa, Uganda			
08.30-09.30	Plenary report and discussion of working group findings	Rapporteur report of the 'take home' challenges and positive approaches from the country work from the two working groups and discussion	Group work rapporteurs
REGIONAL SYNTHESIS OF THE LEARNING AND ISSUES FOR REGIONAL CO-OPERATION Chair: Sue Godt, IDRC Canada			
09.30-10.00	Regional synthesis of the context, motivations, aims, design of the EHBs	Presentation of regional findings	Ms M Mamdani, IHI/EQUINET
10.00-10.30	**TEA**		All
10.30-11.00	Regional synthesis of the issues in implementing and using the EHBs for integrated universal health systems	Presentation of regional findings Proposals and areas for future work (on these areas of focus)	Dr R Loewenson, TARSC/EQUINET
11.00-11.45	Using the EHB for integrated, universal health systems	Moderated discussion Discussion on key questions from the presentations Set up of working groups	Moderator: Dr Dr A Nswilla, PORALG, Tanzania
11.45-13.00	Working groups: National and regional recommendations for policy dialogue on using and reviewing the EHB for integrated, universal health systems	Working groups on key challenges and key positive approaches on EHBs from country experiences. **Group 1: National level.** Building on the country discussions and regional synthesis report, what recommendations for national level on • issues to address, positive approaches, and policy recommendations for developing, resourcing, using and reviewing the EHB • knowledge gaps and areas of further research to support use of EHBs for achieving national goals. **Group 2:** Regional **level.** Building on the country discussions and regional synthesis report, what recommendations for regional level on • areas of regional co-operation to support the national level and negotiate globally on developing, resourcing, using and reviewing the EHB • knowledge gaps and areas of further regional research to support use of EHBs for achieving national and regional goals.	Group 1 Chair: T Moeti, HST South Africa Group 2 chair: Dr A Abdulla, Perm Sec, MoH Zanzibar
13.00-14.15	**LUNCH**		All
MOVING FORWARD: FUTURE WORK IN THE REGION Chair: Dr R Loewenson, TARSC/EQUINET			
14.15-15.45	Report back from working groups Summary	Feedback from the two working groups Discussion o**n policy recommendations,** knowledge gaps and future research? Summary of key recommendations, take home policy messages, follow up at national and regional level	Working group rapporteurs Delegates R Loewenson, TARSC/EQUINET
15.45-15.55	**TEA**		All
CLOSING SESSION Chair: Dr A Abdulla, MoH Zanzibar			
16.00-16.30	Project next steps Closing remarks	Summary of next steps on the project and closing remarks and thanks from EQUINET Closing remarks from MoH Tz, including on behalf of ECSA HC as current chair.	M Mamdani, IHI/EQUINET, Dr A Nswilla PORALG Tz,
16.30	**END OF DAY**		

Appendix 2: Delegate list

LAST NAME	FIRST NAME	COUNTRY	ORGANISATION
Abdulla	Halima	Zanzibar	Deputy Principal Secretary Ministry of Health
Dambisya	Yoswa	Tanzania	Director General East, Central & Southern Africa Health Community
Kadowa	Isaac	Uganda	Principal Medical Officer Ministry of Health
Loewenson	Rene	Zimbabwe	Director and Cluster Lead, Training & Research Support Centre and EQUINET
Mamdani	Masuma	Tanzania	Chief Research Scientist Ifakara Health Institute
Palale	Muunda	Zambia	Director of Budget and Costing TaMuunda Associates Limited
Moeti	Themba Lebogang	South Africa	Executive Director Health Systems Trust
Magagula	Samwel Vusi	Swaziland	Director of Health Services Ministry of Health
Kisanga	Oberlin Eliezer	Tanzania	Head, Health Sector Reform Secretariat Directorate of Policy and Planning Ministry of Health, Community Development, Gender, Elderly and Children.
Nswilla	Anna	Tanzania	Assistant Director, District Health Services Department of Health, Social Welfare and Nutrition President's Office - Regional Administration and Local Government
Godt	Sue	Kenya	Senior Program Officer, MCH Program IDRC Canada
Mlay	Priscilla	Tanzania	EHB Programme Coordinator and Administrator Ifakara Health Institute
Richardson	Faye	Zanzibar	Independent Rapporteur

Apologies:

Abdulla	Asha	Zanzibar	Principal Secretary Ministry of Health
Logose	Juliana Jasmin	Uganda	Information Scientist/ M&E Ministry of Health
Mudyiradima	Robert	Zimbabwe	Principal director, Policy and planning, Ministry of Health