Health benefit packages: moving from aspiration to action for improved access to quality SRHR through UHC reforms.

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The SARS-CoV-2 pandemic has laid bare the challenges for health systems across all countries to deal with major shocks while simultaneously prioritising and maintaining critical services, including essential sexual and reproductive health (SRH) services. Just six months prior to the outbreak, the international community reinforced its commitment to Universal Health Coverage (UHC), under the Sustainable Development Goals (SDGs) for Agenda 2030 through the 2019 UN General Assembly declaration on UHC. UHC includes improved service coverage, quality and financial risk protection, ensuring that people access quality care on the basis of need without suffering financial hardship. In the UHC declaration governments committed to equitable delivery of a package of essential services, including SRH services, medicines and vaccines to the entire population, irrespective of their ability to pay. Even before the SARS-CoV-2 pandemic, it was clear that achieving UHC will require investments in countries’ health delivery systems, and reform of financing and sub-national management systems close to the point of care to achieve improvements in access and utilisation for the most vulnerable groups. However, one of the first steps towards UHC should be to define what services can and will be offered and to whom. Some governments have taken the step of defining a package of essential health services which will have the greatest impact on health outcomes, health equity and financial protection, resonating the UHC targets. This package is defined based on all resources available and the specific burden of disease faced: an explicit health benefits package, known and understood by officials, providers and people which the government commits to provide. Such benefits packages should include affordable, cost-effective, quality primary care and prevention interventions.

As governments unite behind the commitment to UHC we argue that SRHR interventions should address some of the most pressing – and consistent – gaps for women, girls and adolescents serving essential, common and recurring health needs and target vulnerable segments of society with poor access to resources and services. This is particularly the case for preventive and promotive activities such as contraceptives, but also many other interventions including maternal health, cervical cancer treatment and antiretroviral treatment for HIV. Estimates of the cost to deliver a package of essential SRH services suggest that this could provide excellent value for money and that such services are cost-effective. Therefore, in low-resource settings, many components of this package are often highly prioritised on the pathway to UHC.
In recent work, we looked at the content of country health benefits packages in six countries in sub-Saharan Africa; Eswatini, Ethiopia, Malawi, Nigeria, Rwanda and South Africa. In comparison with the Guttmacher-Lancet Commission’s proposed package of essential SRHR interventions, we found that the health benefits packages across these countries include many services around maternal health, HIV and STIs, while areas relating to gender-based violence, comprehensive sexuality education and infertility were omitted or not captured completely, and inclusion of safe abortion services varied depending on the legal and social environment. Based on the case studies we found other more systemic characteristics, which provide five general lessons.

1. **Funding for health is scattered which complicates resource allocation for health benefits packages**

   In Malawi, there are 249 financing sources and 227 implementing partners in the health sector. Although there is a well-articulated Essential Health Package, the levels of fragmentation in both funding and implementation make it very difficult to coordinate financing flows behind a single, good-quality package. The issue of fragmentation in financing is common across many countries, even where donor reliance is not so high. For example, in South Africa, approximately 50% of health spending is concentrated on less than 15% of the population, who receive services through private sector insurance schemes, and within the public sector there is further fragmentation by province and programme. This fragmentation is a source of inefficiency, as resources can be spent on duplicative, inconsistent and cost-ineffective interventions and the government lacks oversight of resource allocation at national, sub-national and facility levels and even down to services in communities. The creation of a benefits package can help to align resources around a common set of priority interventions, but pooling or other financing reforms may also be needed to significantly make the efficiency and equity gains necessary for UHC. Development partners must also be prepared to provide funding in a manner that allows for reallocation of resources between priority areas and cost categories.

2. **Processes for health benefits packages are complex and involve several institutions**

   Every country is taking its own approach to UHC, and to priority setting and the development of benefit packages. Some countries are creating national insurance agencies, some benefit packages are developed and prioritised by the Ministry of Health alone, and others involve Ministries of Finance, Education, Local Government and other related Ministries. In Rwanda, the Mutuelle de Santé package is financed and managed through the Rwanda Social Security Board to reimburse an Essential Health Package designed by the Ministry of Health, which informs clinical practice guidelines and guides health providers on what they should be providing at each level of service delivery. There are often stakeholder groups created to appraise and contribute to the design process, which may involve medical associations, civil society, academic institutions and members of the public. The variety and often lack of integration and concertation fora can make these processes confusing and difficult to engage in for SRHR stakeholders, but their voice, including that of professional associations, patient rights groups and other advocacy groups, is essential for an equitable approach to UHC.

3. **Better country level data is needed, but also more capacity to analyse existing data and use it to improve last mile implementation**

   Generating high-quality, disaggregated data (including by gender, socio-economic status, sexual orientation, disability) at country level is key to making priority setting decisions. There are large contextual differences between countries and between populations within countries in terms of disease burden, access to SRHR services and socio-economic factors affecting utilisation of these services. However, there is often limited local clinical efficacy and economic data, as well as limited capacity, systems or information, to disaggregate data to ensure equity is considered in the prioritisation. For example, in Malawi only 87 of the Essential Health Package’s 250+ interventions were supported by sufficient data on disease burden, efficacy of interventions or cost of implementation for consideration in the cost-effectiveness analysis framework. More and better information is needed on the cost of delivering services in a specific country and clinical efficacy. There is also a need to improve capacity and systems for disaggregating data to ensure that equity is considered in the prioritisation process.
4. **Supply-side challenges exist for delivering on prioritised services**

Even in countries where a prioritised benefit package exists, service delivery is often disconnected from national level policies and packages, as the interventions that can be carried out are reliant upon more practical considerations such as the training and guidelines for health providers regarding diagnosis and treatment, and the personnel, drugs and equipment available at facilities. In order to advance delivery of universal health coverage, it is therefore not sufficient to ensure that services are included in health benefit plans. In most cases, significant additional health systems investments are required to ensure the resources are in place to deliver the package. Rwanda, among other countries, has recognised this and is explicitly mobilising resources to invest in their health system along priorities set out in their benefit package. An explicit benefits package can act as a vehicle to make the investment case for health as it demonstrates an evidence-based, rational approach to optimising health returns, in a fiscal environment where health has to compete with other sectors for resources. This is likely to be increasingly important in the aftermath of the SARS-CoV-2 pandemic, as economic crises evolve into fiscal constraints.

5. **Prioritised services should also be reflected in clinical guidelines and essential medicines lists**

A benefits package, once developed and prioritised, does not necessarily influence what services are available in reality. For example, Eswatini’s Essential Health Care Package is not prescriptive and not directly used to exclude or include services by level of care. To implement the package, the existing pathways through which policy affects implementation should be the primary levers to deliver UHC. Health workers operate according to clinical guidelines that outline care pathways, and facilities are stocked with medicines according to Essential Medicines Lists; these policies and regulations should therefore reflect the priorities of the health benefits package. The National Health Insurance Bill in South Africa commits to delivering at a minimum the services already available in the public sector. Thus a first step towards developing a benefit package is to list explicitly all services based upon the Standard Treatment Guidelines which are closely linked to the Essential Medicines List and are already used to guide service delivery in the public sector. SRHR stakeholders that seek to engage with the UHC process in any given country should take advantage of these existing tools and guidelines and ensure that the Essential Medicines List contains the recommended SRHR commodities, consider the WHO Model List of Essential Medicines, and ensure that clinical guidance is in line with regional and global norms and standards.

During and after the SARS-CoV-2 pandemic response, the principles motivating an explicit benefits package will be even more important for enabling progress towards UHC and universal access to SRHR. The ongoing pandemic has placed both economic and health systems under tremendous stress and countries have redirected resources to the pandemic response. In consequence, health systems in lower- and middle-income countries are reconfiguring their priorities around urgent needs for testing, hospitalisation and critical care, and infection protection and control measures, as well as broader economic and social interventions. With this dominant focus on combating COVID-19, there is a risk of reallocation of resources away from essential services, including SRHR priorities, at least in the short term, and considerable opportunity costs of this reallocation upon population health. The response to Ebola illustrated that the neglect of routine services like SRHR and immunisation, for example, leads to much added misery especially for the poor. Any re-prioritisation, as well as additional costs of existing essential services, should be explicitly built into the benefits package so that these decisions are being made system-wide, rationally and transparently, without increasing verticalisation of programmes or fragmentation of resources. There will likely be even greater need to focus on cost-effectiveness, quality of care and equity, given the likely fiscal contractions mentioned above, already fragile health finances and the anticipated disproportionate impact upon those living in poverty. Innovative solutions such as self-care should be leveraged, and increased efforts are needed to support multisectoral health promotion strategies to prevent downstream costs to already stretched health systems.

When a fair and transparent priority setting process considers the best available evidence, burden of disease, and cost effectiveness, and is underpinned by ethical values such as equity, gender equality and right to health, SRHR services will, to a large extent, be included in health benefits
packages as being essential for progress towards UHC. If these benefit packages are used to guide how resources are allocated to health facilities and providers in practice, they will translate into increased access to SRHR services. Therefore, health benefits packages have the potential to advance access to essential SRHR interventions within the health sector and contribute to the UHC goal of realising the right to the highest attainable standard of health without suffering financial hardship, including meeting the unique needs of women, girls and adolescents.

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References
1. United Nations. Political declaration of the high-level meeting on universal health coverage “universal health coverage: moving together to build a healthier world” A/RES/74/2. New York: United Nations; 2019.
2. Aman A, et al. Financing universal health coverage: four steps to go from aspiration to action. Lancet. 2019;394(10202):902–903.
3. Starrs AM, Ezeh AC, Barker G, et al. Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. Lancet. 2018;391(10140):2642–2692.
4. United Nations Populations Fund. Supplement to background paper on universal access to sexual and reproductive health and rights as an essential element of universal health coverage. 2019.
5. The Partnership for Maternal Newborn and Child Health. Prioritizing essential packages of health services in six countries in sub-Saharan Africa: implications and lessons for SRHR. 2019.
6. Republic of Malawi Ministry of health and population Malawi, Resource Mapping Round 6;15–20:2019.
7. Health Systems Trust. South African Health Review. 2019, Republic of South Africa.
8. Ochalek J, Revill1 P, Manthalu G, et al. Supporting the development of a health benefits package in Malawi. BMJ Glob Health. 2018;3(2):e000607.
9. Ministry of Health Rwanda. Health Financing Strategic Plan 2018-2024. 2019, Republic of Rwanda.
10. Governments of Sweden and South Africa on behalf of 39 signatories. Joint press statement Protecting Sexual and Reproductive Health and Rights and Promoting Gender-responsiveness in the COVID-19 crisis. 2020.