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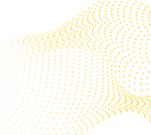
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# Health Benefit Packages and inclusion of health products to increase UHC

## *Focus on Sub Saharan Africa*

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## Introduction

Universal Health Coverage (UHC) represents a foundational goal in global health policy. It aims to ensure that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. However, the global effort to achieve UHC by 2030, as outlined in Sustainable Development Goals target 3.8, is currently falling short. Progress in expanding health services coverage has stalled since 2015, and the percentage of people experiencing catastrophic out-of-pocket (OOP) health expenses has steadily increased since 2000 across all regions and most countries.

In the WHO African Region (AFRO), the UHC service coverage index<sup>1</sup> has shown some improvement over the past two decades, but the rate of progress has slowed since 2015. In 2021, the index declined slightly from 45% to 44% compared to 2019, likely influenced by the COVID-19 pandemic.

While there has been some reduction in the number of people pushed into extreme poverty due to OOP health expenditures, the percentages facing impoverishing health costs at the 10% threshold and those experiencing catastrophic OOP expenses have stagnated over the last two decades. This situation underscores the need for targeted policy changes in the region (WHO AFRO, 2023).

Total health spending in SSA is low, averaging just \$92 per person in 2021, with projections suggesting a further decline to \$86.30 by 2050<sup>2</sup>. Many countries in the region rely heavily on external funding, with almost half depending on it for more than one-third of their health expenditures. In contrast, domestic government contributions average only 40%, significantly lower than the global average (63%).

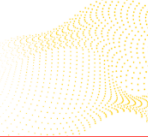
Specific data on health product spending in LMIC's is scarce, especially in SSA. Estimates indicate that medicines account for a large share (between 20-60%) of health expenditures in LMICs. Of that share, OOP payments are the primary source of funding (50% to 90%)<sup>3</sup>. This reliance is even more pronounced among the poor<sup>4</sup>. The data behind these figures is over 20 years old, there is an urgent need to update this data to ensure sound policy recommendations but also for policy interventions that address affordability and access to essential medicine.

<sup>1</sup> Coverage of essential health services defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage.

<sup>2</sup> Apeagyei et al. (2024)

<sup>3</sup> 2004 WHO "World Medicines Situation"

<sup>4</sup> The World Health Survey (2003)



## Health Benefit Package (HBP)

One of the policy instruments that are used in progressing towards UHC are Health Benefit Packages (HBP). A HBP is the selection of health services provided at a certain coverage of costs and for a certain population. As public resources are limited, no country is able to provide all health services for their population with public funding. The design of a HBP reflects the choices across three axis of the UHC Cube (Services, Coverage & Population). Each health system has a HBP, which may be an explicit or only implied package, referring to the current service provision in the country.

1. Essential benefit package design should be impartial, aiming for universality
2. Essential benefit package design should be democratic and inclusive with public involvement, also from disadvantaged populations
3. Essential benefit package design should be based on national values and clearly defined criteria
4. Essential benefit package design should be data driven and evidence-based, including revisions in light of new evidence
5. Essential benefit package design should respect the difference between data, dialogue, and decision
6. Essential benefit package design should be linked to robust financing mechanisms
7. Essential benefit package design should include effective service delivery mechanisms that can promote quality care
8. Essential benefit package design should be open and transparent in all steps of the process and decisions including trade-offs should be clearly communicated

### *Best practices in HBP design*

The WHO & WB recommend HBPs to formulate an explicit, minimum package of services based on cost-effectiveness to reduce the overall burden of disease. Implicit HBP are difficult to implement; when services are not well defined and/or the list of services is aspirational, it is unclear if the financial, human and material resources are in place to provide the services at the desired coverage level. To support countries with the design of their HBP packages, the WHO has drafted some

policy notes including a [note on the 8 principles for the design of an HBP](#) (WHO, 2021).

Once defined, HBPs need to be reviewed on a regular basis to take into account changes in burden of diseases, political priorities, fluctuating health budgets and innovations in health and health care. Other criteria to take into account when reviewing HBP are equity and access of the most vulnerable, social and economic impact. Revision processes are ideally based on both evidence-informed decision making as well as a deliberative process involving relevant stakeholders to ensure the results are seen as fair by the population. The review process is generally initiated by the MoH and can involve a variety of other stakeholders ranging from academia, health providers, development partners, insurance funds, subnational governments, civil society and should involve the Ministry of Finance.

HBP design starts from health services but health products are an essential component of health care delivery. WHO has developed tools to support countries with the design and selection of health services and products to improve UHC such as UHC compendium, Model essential medicines list and Health Technology Assessment methodologies. The

next section presents some of the tools and methods with a specific focus on the link to health products.

## WHO UHC compendium

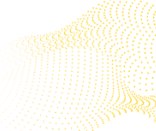
The UHC Compendium offers evidence-based guidance on which health services to include in a UHC package to optimize health outcomes and ensure financial protection. Importantly, the compendium also connects these services to the necessary essential medicines, medical devices, and laboratory tests.

The compendium features both global and thematic reference lists to support its recommendations. For instance, the DCP3 reference list outlines priority health interventions for UHC in LMICs, including the “Essential UHC” and a subset known as the “Highest Priority Package”. Additionally, the compendium includes the “Service Planning, Delivery & Implementation (SPDI)” tool, which allows users to tailor the reference lists to their country's specific context, taking into account demographic, epidemiological, political, and economic factors. This tool enables health policy officers to generate a country-specific list of services and extract a customized spreadsheet of health products needed to implement the HBP.

As noted, these resources can be used to review current policies and lists, as countries often have existing HBP, national essential medicines lists or reimbursement lists to build upon.

**Figure 1 Example of resource extract from the SPDI tool**

DCP3_HPP									
Date : 20 August 2024									
Scope: Medicines, products, kits, sets and IVDs for all services									
Option: With filters applied + Include medications, products, IVDs by emergency health kits and essential resources for emergency care (EREC)									
<a href="https://dhts.edh.im">https://dhts.edh.im</a>									
EML Section Headers		EML Medication N EML status		ATC Code		HC	FLH	RH	EML Formulations
1. Anaesthetics, preoperative medicines and medical gases									Units per day - SPC Number of days
1.1.1. General anaesthetics and oxygen > Inhalational medicines	Halothane	Respiratory > Inh	N01A801				O		Respiratory > Inhalation > liquid: 1
	Isoflurane	Respiratory > Inh	N01A806				O		Respiratory > Inhalation > liquid: 1
	Nitrous oxide	Respiratory > Inh	N01A13				O		Respiratory > Inhalation: 1
1.1.2. General anaesthetics and oxygen > Injectable medicines	Ketamine	Parenteral > Gen	N01AX03				O		Parenteral > General injections > unspecified: 50 mg per mL in 10 mL vial: 1
1.1.2. General anaesthetics and oxygen > Injectable medicines	Ketamine	Parenteral > Gen	N01AX03				O		Parenteral > General injections > unspecified: 50 mg per mL in 10 mL vial: 1
1.1.2. General anaesthetics and oxygen > Injectable medicines	Ketamine	Parenteral > Gen	N01AX03				O		Parenteral > General injections > unspecified: 50 mg per mL in 10 mL vial: 1
1.1.2. General anaesthetics and oxygen > Injectable medicines	Ketamine	Parenteral > Gen	N01AX03				O		Parenteral > General injections > unspecified: 50 mg per mL in 10 mL vial: 1
1.1.2. General anaesthetics and oxygen > Injectable medicines	Propofol	Parenteral > Gen	N01AX10				O		Parenteral > General injections > IV: 10 mg per mL; 20 mg per mL: 1
1.2. Local anaesthetics	Bupivacaine	Parenteral > Locc	N01BB01			O			Parenteral > Locoregional injections > Spinal anaesthesia: 0.5% in 4 mL: 1
1.2. Local anaesthetics	Bupivacaine	Parenteral > Locc	N01BB01			O			Parenteral > Locoregional injections > Spinal anaesthesia: 0.5% in 4 mL: 1
1.2. Local anaesthetics	Bupivacaine	Parenteral > Locc	N01BB01			O			Parenteral > Locoregional injections > Spinal anaesthesia: 0.5% in 4 mL: 1
	Bupivacaine hydro	Parenteral > Locc	N01BB01				O		Parenteral > Locoregional injections > Spinal anaesthesia: 0.5% in 4 mL: 1
	Ephedrine	Parenteral > Locc	C01CA26				O		Parenteral > Locoregional injections > Spinal anaesthesia: 30 mg per mL: 1
	Lidocaine	Parenteral > Locc	N01BB02			O			Parenteral > Locoregional injections > Spinal anaesthesia: 5% in 2 mL amp: 1
	Lidocaine	Parenteral > Locc	N01BB02			O			Parenteral > Locoregional injections > Spinal anaesthesia: 5% in 2 mL amp: 1



## WHO and national Essential Medicines List

Essential medicines are those that meet the priority healthcare needs of a population. The concept has strong global support. The WHO publishes<sup>5</sup> updates of the Model List of Essential Medicines (EML) and Model List of Essential Medicines for Children (EMLc) every two years. The list is based on disease and public health relevance, evidence of efficacy and safety and comparative cost-effectiveness. The most recent updates from July 2023 are the [23<sup>rd</sup> EML](#) and the [9<sup>th</sup> EMLc](#)<sup>6</sup>.

These lists are intended to ensure that essential medicines are available in functioning health systems at all times, in appropriate dosage forms, of assured quality, and at prices that individuals and health systems can afford. The WHO Model List serves as a guide for countries and regional authorities to adopt or adapt, based on local priorities and treatment guidelines, in developing or updating their own National Essential Medicines Lists (NEMLs).

NEMLs serve different purposes across countries; in some, they guide procurement, while in others, they influence reimbursement decisions. A well-maintained NEML can improve access to essential medicines by streamlining procurement and distribution, promoting rational prescribing practices, and reducing costs for both healthcare systems and patients. WHO guidelines recommend reviewing NEMLs every two years to ensure that innovative medicines are included and outdated ones are removed.

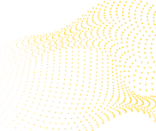
However, the presence of an NEML does not guarantee that the listed medicines are available or affordable in the country. There is often no direct link between the review process of NEML and the (explicit) HBP as these can be overseen by different bodies. NEMLs are not always updated regularly and inclusion on the list does not guarantee that pharmaceutical manufacturers register their products in the country.

## Health Technology Assessment (HTA)

Countries who already have clearly defined and established essential services may evaluate new health services or technologies through the HTA mechanism. HTA is a methodology for selecting pharmaceuticals, clinical procedures, and medical devices for inclusion in HBP, reimbursement, budgeting, and insurance programs. In more advanced health systems, specialized staff evaluate dossiers submitted by pharmaceutical manufacturers, which include clinical and economic evidence along with data on budget

<sup>5</sup> The first [EML](#) was published in 1977, and the first EMLC was published in 2007.

<sup>6</sup> Other WHO prioritization model lists are WHO Model List of Essential In Vitro Diagnostics ([EDL](#)) and WHO list of Priority Medical Devices ([MEDVIS](#)).



impact. This assessment aids in providing recommendations or decisions regarding inclusion in reimbursement and benefit packages.

## Recommendations

To advance Universal Health Coverage (UHC) in Sub-Saharan Africa (SSA), targeted policy reforms are urgently needed. Key actions should focus on increasing domestic funding, reducing out-of-pocket (OOP) expenditures, and improving equitable access to essential health products. Recommendations to ensure equitable access to health products include: Advocating for sustainable health (product) financing, work on appropriate governance structures (including regulatory frameworks, rational use policies and oversight of the supply chain), Ensure well trained health workforce (incl. pharmacists, HC providers and procurement & supply managers) as well as improve adequacy of information systems to able to track availability and prices of health products to support informed decision making.

Practical recommendations for policy officers working on national HBP programs:

### 1. Document current Health Benefit Package for the country

Clearly describe the existing HBP for your country. Identify which packages are in place, who is covered (e.g., specific populations or universal), level of coverages and whether the package design is explicit (clearly defined services and coverage) or implicit.

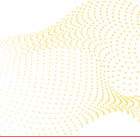
If applicable, also document the revision process including roles and responsibilities and periodicity. When was the HBP last revised, who is initiating a review process and who is involved/consulted. At what administrative level are the HBP defined (national, regional, or sub-national)?

Finally describe how is the HBP (and potential updates) are communicated to the population, is the process transparent and is the information easily accessible to the general public?

### 2. Analyse appropriateness of current HBP including cross checking with EML lists.

Assess whether the HBP reflects the country's current national health priorities including current disease burden, evolving political priorities including to budget constraints and adaption to evolutions in terms of health interventions.

Utilize reference tools like the UHC Compendium to evaluate the current service provision and the current availability of essential health products. Cross check these findings with other national policies such as the national EML and the market authorisation list. Assess



whether the medicines listed across different national policies are adequately addressing the country's disease burden and are part of the service delivery outlined in the HBP.

Review at what level of coverage these medicines are provided at different dispensing points in the health system (e.g. different levels of health facilities or at private retailers). Identify if data on availability at these dispensing location is available for your country.

Engage Stakeholders key stakeholders, including the Ministry of Health, Ministry of Finance, national regulatory authorities, healthcare providers, academia, and civil society in the analysis of the HBP.

### 3. Identify and prioritize areas for improvement of the HBP

Based on the analysis and stakeholder input, highlight key areas where the HBP needs improvement. Focus on priority areas such as enhancing coverage for underserved populations, addressing financial barriers, updating health interventions, or better aligning with the latest health trends. Prioritize reforms based on feasibility, impact, and alignment with national health goals. Ensure that other policy instruments such as nEML and national reimbursement lists are aligned with the revised HBP.

Finally include an action plan to inform the population of the changes in HBP and the level of coverage that they can expect.

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