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Title: Re-defining Ethiopia's Essential Health Services Package on the Path Towards Universal Health Coverage: The What and How?

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Abstract:

Ethiopia has come a long way towards improving the health of the population over the last 20 years. To make this progress, the health sector has developed and implemented a well-tailored series of strategic plans, leveraged the potential of other government sectors and development partners, and adopted and introduced innovative service delivery strategies particularly for the Essential Health Services Packages (EHSP) in 2005.

With the transition from the Millennium Development Goals (MDGs) to the more ambitious Sustainable Development Goals (SDGs) for health, the sector needs to shift gears to increase the scope of health services, maximize efficiency and effectiveness of delivery platforms, and re-examine the finance mechanisms. Revising, expanding and financing the essential health services package is arguably the most important step in this transition. The existing package, defined in 2005, needs to be updated to reflect changing demographic and epidemiological trends that have come with an ageing population and the rise of non-communicable diseases (NCDs). Additionally, economic growth has led to increased public expectations in both rural and urban areas of the country for the health system performance. With the process established to support health priority setting in Ethiopia, including assessing the burden of disease, evidence of intervention effectiveness, and cost-effectiveness of selected health sector interventions, packages, and platforms, Disease Control Priorities-Ethiopia (DCP-E) will help to provide evidence for scaling up health interventions and refine health packages and policies toward Universal Health Coverage (UHC). These economic evaluations will highlight the health and economic benefits and the equity impact of moving towards UHC for Ethiopia. It will identify critical trade-offs in a resource-constrained setting (e.g. equity vs. efficiency) using all dimensions of UHC including financial risk protection (FRP).

This paper synthesizes evidence and provides recommendations for how to set priorities to re-define the EHSP on the path towards UHC. To achieve UHC, countries must advance along three important dimensions: expanding priority services, including more beneficiaries, and FRP including reducing out-of-pocket payments. Balancing between all these three dimensions while emphasizing quality and equity is essential to achieving UHC in Ethiopia. In this paper, we discuss the background of the EHSP in Ethiopia and propose guiding principles for the revision of the EHSP, taking into account the three criteria of (i) value for money, (ii) equity and fairness, and (iii) financial risk protection.

1. Introduction

1.1 BACKGROUND

The Ministry of Health of Ethiopia has conducted a series of consultative meetings with key stakeholders, has launched its 5-year Health Sector Transformation Plan and is now finalizing its 20-year Health Sector Envisioning of the health sector and is revising the National Health Policy (Ethiopia 2015a, c, e). The first comprehensive National Health Policy (NHP) was articulated in 1993, taking into account the past, present needs and future challenges. The NHP has been translated into practice through four rounds of the Health Sector Development Plans (HSDPs) I-IV (Ethiopia 2015c). As a result, Ethiopia has made commendable achievements over the past two decades (WHO 2012c).

Ethiopia has made moving towards Universal Health Coverage (UHC) its primary health sector development goal. UHC is defined as all people being able to receive quality health services that meet their needs without being exposed to financial hardship in paying for those service (WHO 2010). UHC does not mean all possible services. Rather it means a comprehensive range of key services that is well aligned with other social objectives (WHO 2014). In Ethiopia, this comprehensive range of services will be progressively rolled out, first through primary health care and the flagship Health Extension Program (HEP) (Ethiopia 2015a). The introduction of the HEP in 2003 and the definition of the Essential Health Services Package (EHSP) in 2005 were game-changers in the history of the Ethiopian health sector. The HEP brought a different perspective and approach to health service delivery in the country i.e. “bringing services to the people”, and not “bringing people to the services” and introduced its new philosophy, “if the

right knowledge and skill is transferred to households, they can take the responsibility for producing and maintaining their own health" (Ethiopia 2015b).

To achieve UHC, countries must advance along three important dimensions: expand priority services, include more beneficiaries, and provide financial risk protection including reducing out-of-pocket payments (WHO 2010). Balancing these three dimensions while emphasizing quality and equity of the health services, is essential to achieving UHC (Woldemariam 2016).

Revising, expanding and financing the essential health services package is arguably the most important step in this process for Ethiopia. The existing package from 2005, needs to be updated to reflect new developments. These include demographic and epidemiological trends that have come with an ageing population and the rise of non-communicable diseases (NCDs). Additionally, economic growth has led to increased public expectations of the health care system in both rural and urban areas of the country (Ethiopia 2005).

In this paper, we discuss the background of the EHSP in Ethiopia and propose guiding principles for the revision of the EHSP, taking into account the three criteria of (i) value for money, (ii) equity and fairness, and (iii) financial risk protection.

1.2 THE ETHIOPIAN CONTEXT

1.2.1 Performance on the Millennium Development Goals

The launch of the Millennium Development Goals (MDGs) coincided with the first year of implementation of HSDP II. This gave the health sector the unique opportunity to align its goals with the MDGs which led to donor support. According to the latest estimates by the United Nations, Ethiopia achieved most of the health-related MDGs (MDGs 4, 5 & 6) (Admasu 2015).

These achievements are linked to clear policies and strategies, community empowerment and ownership through the HEP and the Health Development Army strategy, unprecedented and well-aligned support from Ethiopia's donors, and economic growth (WHO 2012a). In spite of these achievements, the Health Vision 2035 and the Health Sector Transformation Plan (HSTP 2015-2020) accounted for the incompleted areas of the MDGs (Ethiopia 2015a, c), particularly around equity and quality of healthcare.

1.2.2 The Health Sector Transformation Plan (HSTP) 2015-2020

Quality and equity are the hallmark of the HSTP. The HSTP has set ambitious goals like reducing the maternal mortality ratio (MMR) to 199 per 100,000 live births by 2020. Its 15 strategic objectives range from supply chain to regulatory frameworks, from capacity building to community ownership, with a vision to see healthy, productive and prosperous Ethiopians.

1.2.3 Ethiopia's health vision 2035 and the Sustainable Development Goals

Ethiopia aspires to become a lower middle-income country by 2025, and middle middle-income by 2035 with gross national income per capita of $4,125 (WB 2017). The Ministry of Health (MoH) has conducted an "envisioning of the health sector" (Kesetebirhan Admasu 2014) exercise towards UHC. The objective of this long-term planning exercise is to define a framework for strategic action to enable Ethiopia to achieve the health outcomes of a lower middle-income country by 2025 and of a middle-middle-income country by 2035. The vision is anchored on six strategic pillars: i) to empower the community to play a significant role in the health sector; ii) to strengthen primary health care units (PHCU) within the larger health sector context; iii) to ensure a robust Human Resources Development system that is commensurate with socioeconomic development of the country; iv) to enhance the role of non-state actors in support

of the sector's vision; v) to develop sustainable financing mechanisms; and vi) to develop capacity in the health sector to be responsive to the changing economic, social, environmental, technical, and epidemiologic context.

1.2.4 The health policy and its revision

The 1993 National Health Policy was developed from an understanding of the nature, magnitude and root causes of the prevailing health problems of the country and the awareness of newly emerging health problems. It is founded on a commitment to democracy and the rights of the people that derive from it and to decentralization as the most appropriate system of government for the full exercise of these rights and powers in the pluralistic Ethiopian society. It gives appropriate emphasis to the needs of the less-privileged rural populations which constitute the overwhelming majority of the population, roughly 85% (WB 2016), and the major labor force of the nation. As enunciated in its articles, it proposes realistic goals based on the fundamental principle that health is a prerequisite for the enjoyment of life and optimal productivity.

Taking into account global and regional realities as well as the three important transitions (epidemiological, demographic, risk), Ethiopia's health policy is being revised. The revised policy, which is part of the country's socioeconomic development policy, perceives health as a human rights issue and an investment to improve the economy of the country. In general, health development should be seen not only in humanitarian terms but as an essential component of the packages. It should also be seen as an instrument for social justice and equity. It should incorporate major policy priority areas, directions, strategies and policy implementation frameworks to guide subsequent long- and short-term road maps, implementation strategies and operational plans in the health and health-related sectors (Ethiopia 2015e).

1.3 ETHIOPIA'S ESSENTIAL HEALTH SERVICES PACKAGE

Ethiopia's essential health services package (EHSP) was defined in 2005. It outlined the type of services to be included and the levels of service provision (community, health center/post, district-level hospital). The package should be available to all Ethiopians irrespective of income, gender, and place of residence (Table 1). These promotive, preventive, curative, and rehabilitative interventions are considered to be the minimum that people can expect to receive through the various health delivery mechanisms and facilities within their reach. The scope of the EHSP is limited to the provision of essential services at the health post, health center and district hospital levels (Ethiopia 2005). Since 2005, more services have been added and provided free of charge or substantially subsidized.

1.3.1 Components and strategic approaches of the EHSP

The major components of the EHSP for Ethiopia builds on the essential package of services from the HEP at the community level. A category containing basic curative care and treatment of major chronic conditions is introduced starting from the community level. Thus, EHSP is organized into the following five components: 1) family health services; 2) communicable disease prevention and control services; 3) hygiene and environmental health services; 4) health education and communication services; 5) basic curative care and treatment of major chronic conditions (Table 1).

Interventions chosen to address the major causes of death and disease are detailed for key health services subcomponents falling under each major component. The interventions are to be provided by a range of providers within a district health system that comprises a health post, health center, and district hospital.

Table 1. Components of the essential health services package (EHSP), 2005.

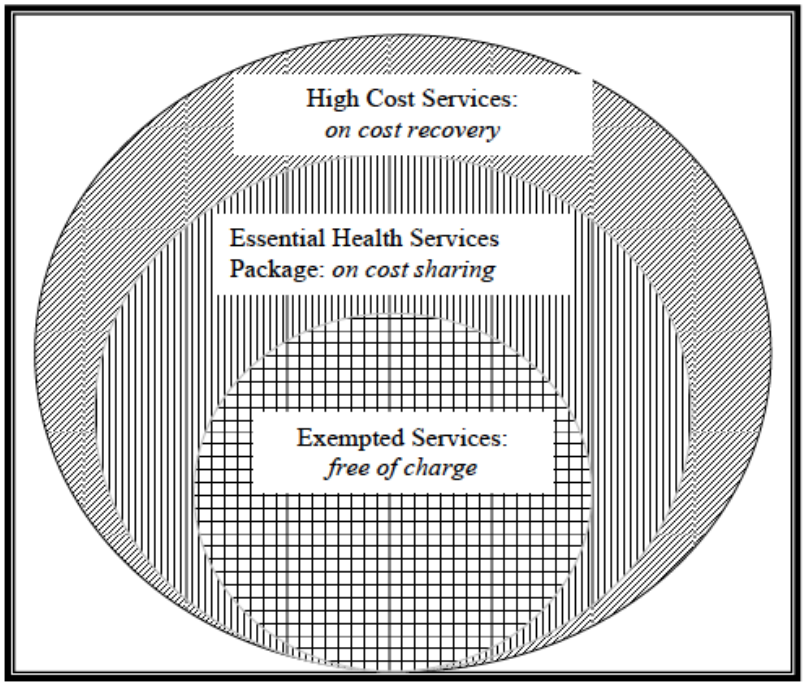
Family Health: ✓ ANC ✓ Delivery ✓ Newborn Care ✓ PNC ✓ FP ✓ Child Health (EPI, IMCI, Growth monitoring, Essential Nutrition Action) ✓ ARH	**Communicable Diseases:** ✓ Tuberculosis ✓ Leprosy ✓ HIV/AIDS and other STIs ✓ Epidemic prone diseases ✓ Rabies
Basic Curative Care and Treatment of Major Chronic Conditions: ✓ School health education & screening students for major chronic problems and disability ✓ Oral hygiene, care and treatment ✓ Public education on common emergency conditions ✓ Information, Education and Communication Campaign (IEC), care and treatment for DM, hypertension ✓ Orthopaedic care and treatment (ranging from application of splint for fractures & referral to Stabilization of fractures with splint at HC level to specific diagnosis of fractures with X-ray support and immobilization including by POP application at DH) ✓ Emergency medical care and treatment care ✓ Education, care and treatment for eye infections, allergies and foreign body ✓ Treatment of diarrhoea with its complications ✓ Treatment of malaria , typhoid fever and RF ✓ Treatment of intestinal parasite infestation ✓ Care and treatment for epilepsy ✓ Removal of foreign body in the nose & ear ✓ UTI treatment ✓ Treatment and care for bronchial asthma and pneumonia ✓ Blood transfusion services	**Hygiene and Environmental Health:** ✓ IEC & Demonstration of small do-able environmental health actions ✓ School health education ✓ IEC and demonstration of proper housing, sanitation and proper solid waste disposal ✓ Education on personal and food hygiene and safety practices ✓ Education, inspection , screening and treatment of students for contagious eye and skin diseases and provision of appropriate treatment ✓ Prison health service, control of rodents and insects, & delousing when needed ✓ Proper water management and water quality control ✓ Disease surveillance
Health Education and Communication: Community mobilization & sensitization, Counseling service Development, provision and distribution of IEC materials, group and individual IEC in community and at home	

The rationale behind formulating the package as outlined above was a mismatch between resources and the demand for health services. An additional component was the need to prioritize services. In general, the definition of an essential benefits package enhances focus on priorities, cost-effectiveness and efficient use of resources. It also fosters integrated health service delivery by calling attention to a package rather than to individual programs. In this way the package can also be used as a basis for the development of district plans that respond to local priorities (Ethiopia 2005). The EHSP has also played a critical role in achieving the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) which evolved from the Sustainable Development and Poverty Reduction Program (SDPRP), and the Growth and Transformation (GTP) Plans.[1] The main objectives of these plans were to define the nation's overall strategy for development, lay out the directions for accelerated, sustained, and people-centred economic development as well as to pave the groundwork for the attainment of the MDGs by 2015.

The EHSP took into consideration certain values and principles including: 1) cost-effectiveness; 2) affordability in terms of the country capacity to provide the services; 3) equity to ensure equal access and utilization of health care according to the needs of the populations; 4) necessity which implies inclusion of services that when missed, will have a disastrous and intolerable outcome as in the case of exposure to rabies; 5) human resource and organizational capacity; and 6) physical and financial accessibility to essential services (Ethiopia 2005).

[1]The Plan for Accelerated and Sustained Development to End Poverty (PASDEP), Ethiopia's guiding strategic framework for the five-year period 2005/06-2009/10, represents the second phase of the Poverty Reduction Strategy Program (PRSP) process, which has begun under the Sustainable Development and Poverty Reduction Program (SDPRP), which covered 2002/03-2004/05. The Growth and Transformation Plan (2010/11-2014/15) was developed based on the country's long term vision, achievements of PASDEP and lessons drawn from the implementation of the PRSP and the PASDEP. It also considered growth constraining factors that emerged in the course of implementation and external shocks.

Figure 1. Current financing arrangements of the health sector, including Ethiopia's essential health services package (EHSP). Source: EHSP for Ethiopia 2005.



The EHSP outlines the content of three service categories and how they should be financed. These include "Exempted Services" free of charge; "Essential Health Services Package" financed by cost sharing; and "High cost Services" financed on cost recovery (Figure 1).

1.4 EVOLUTION AND REVISION OF THE PACKAGE ON THE PATH TOWARDS UHC

1.4.1 Rationale for the revision

Population demands have increased as the health and health system literacy of citizens has improved. The Health Insurance Strategy from 2008 states that the aim of introducing health insurance is to provide universal primary health services to all Ethiopians (Ethiopia 2008a). The

strategy defines the packages for the Community-Based Health Insurance (CBHI) and Social Health Insurance (SHI) schemes. EHSP is the basis for both schemes. It is important to harmonize these schemes guided by available evidence and priority setting principles and to merge them toward a single revised EHSP which further advances the path towards UHC. Once the EHSP is revised it can better guide the health insurance package and the harmonization of the two schemes into one consolidated set of services.

EHSP has evolved since its inception. A good example is the provision of integrated NCD services at the primary health care level with for instance the visual inspection of the cervix and application of acetic acid for cervical cancer, diabetes care especially for children, and several mental health services (Ethiopia 2015d, 2008b, 2010).

The HSTP also provides motivation for revision. Developing "Caring, Respectful and Compassionate" (CRC) (Admasu 2015) health care providers is one of the four transformation agendas of the plan. The CRC movement is part of the evolution of this package. In addition to the package itself, it is equally important to make sure that the services are being provided to all Ethiopians without financial strain, with equity, quality and high standards, and that people are cared for respectfully and compassionately. Key ethical principles also form the underlying rationale for fair priority setting. The revision therefore has to take into account issues of quality and the CRC framework. In addition, it is imperative to note that providing quality services without financial risks contributes to the creation of healthy, productive and prosperous citizens which, is ultimately a key driver of shared national prosperity. In other words, poverty reduction and a prosperous nation are unachievable without healthy citizens.

2. Methods

2.1 Cost-effectiveness and efficiency

When categorizing and selecting which services to expand next, it is often useful to start with a cost-effectiveness analysis. Most of the currently exempted services and many of those listed among the essential health services have been shown to be highly cost-effective. One very good example is the vaccination programme (Logan Brenzel 2006). Many national and international initiatives have suggested that cost-effectiveness is one key input to the prioritizing of health services (Beaglehole 2011; DCP3 2013). It will likely be unfair if a health system covers services that are not cost-effective while numerous individuals are dying from diseases that can be effectively treated at low cost (Norheim 2015). In practice, generating and using cost-effectiveness data can be challenging. However, such data are increasingly available from the Disease Control Priorities project, WHO-CHOICE, and Tuft University's CEA database (Jamison and others 2006; WHO 2012b), and several practical guidelines and tools now exist (Tan-Torres Edejer and others 2003; WHO 2012b). Moreover, even an imperfect application of the cost-effectiveness criterion—combined with other relevant criteria—is likely to be better than ignoring cost-effectiveness entirely, since there is huge variation in cost-effectiveness across services. Countries like Ghana, Mexico and Thailand have used cost-effectiveness as one of several criteria for defining essential services (Glassman 2012).

In addition, technical efficiency in implementation is key. Technical efficiency means better outputs for the same input, and studies have shown that health outcomes can be improved substantially by improved efficiency (WHO 2010).

2.2 Equity

The public generally finds an exclusive focus on cost-effectiveness indefensible. Standard cost-effectiveness analysis is concerned with the total number of healthy life years gained per incremental expenditure. This analysis counts every additional healthy life year as equally important, no matter whether the additional benefit would accrue to a person with very bad health or to someone with only a small reduction in health. Equitable distribution and equity recommend priority of services benefiting the worse off, either defined in terms of health or socioeconomic status (WHO 2014). As for policy, priority to the worse off in terms of health—often with reference to "need," "severity," or "urgency"—has also figured centrally in many national guidelines on priority setting in high-income countries (Ottersen 2016; Sabik and Lie 2008; van de Wetering and others 2011). Priority to the worse off can also mean extra priority to the most disadvantaged groups, such as people living in hard to reach areas, or people with lower socioeconomic status.

2.3 Financial Risk Protection

Financial risk protection is a key objective for UHC and health systems (Roberts 2003; WB 1993; WHO 2000, 2010). Large out-of-pocket payments for health services can cause severe financial strain on a patient and his or her family, and the proportion of health service costs paid out-of-pocket is high in Ethiopia. For example, examining Ethiopia's public and private expenditures from the national health accounts, we see that the fraction of healthcare expenditures borne out of pocket by households in 2011 was: 2% for HIV/AIDS, 14% for malaria, 28% for reproductive health conditions, 26% for tuberculosis, 48% for child health conditions, and 53% for "other" conditions (WHO 2010). Subsequently, Ethiopian households

can be exposed to high financial risks when seeking healthcare. As a case in point, two recent studies (Memirie 2017; Tolla 2017) showed that patient-incurred costs related to childhood conditions (e.g. pneumonia, diarrhea) and cardiovascular disease were very high and could subsequently lead to impoverishment.

Therefore, financial risk protection is relevant for the selection and expansion of services (World Health Organization 2014). When selecting the interventions to be included in the essential health services package, policymakers should consider the protection of families against financial impoverishment, in addition to increasing health benefits. Public finance of key interventions could bring major financial protection benefits in addition to substantial health gains, and cost-effective interventions such as treatment for hypertension can lead to large poverty reduction benefits (WHO 2000).

Policy makers should take both health and financial risk protection into account when making decisions. Consequently, scarce healthcare resources could be more effectively targeted in accordance with specific policy objectives. For example, although potentially medium- or low priority on the grounds of health benefits, an intervention might be included in a benefits package based on its financial protection benefits. Similarly, if two interventions provide similar amount of financial protection per incremental budget expenditure, the intervention which provides the more financial protection could be provided until resources are available for both. Finally, with the inclusion of financial protection, investments in health policies and interventions can then be compared with investments in policies from other sectors aimed at poverty reduction (e.g. education, transportation, and development).

Specification of the essential health services package

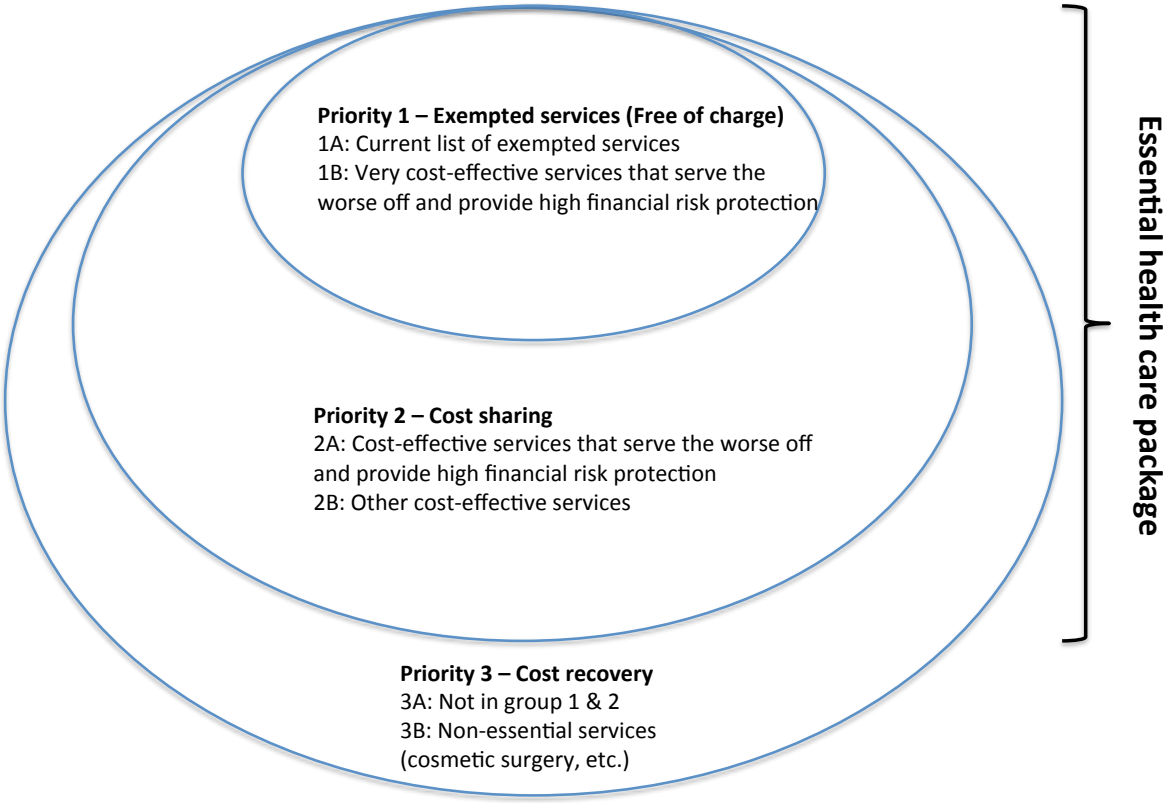
In summary, three criteria are proposed: cost-effectiveness, priority to the worse-off (equity), and financial risk protection. Since improving health in the population is the primary purpose of the health system, one useful strategy is to start with cost-effectiveness data to roughly stratify services into priority classes and then make adjustments based on the two additional criteria of equity and financial risk protection as described above (figure 2).

In the absence of comprehensive cost-effectiveness data, we propose that services are classified as very cost-effective if the cost-effectiveness ratio is below 50% of gross national income (GNI) per capita; cost-effective if between 50% and 150% of GNI per capita; and not cost-effective if more than 150% of GNI per capita (Woods B. 2015).

To determine which services to expand next within this framework, the Ministry of Health will, in addition to the services listed in the current EHSP document, generate a list of additional services to be considered. Each service can then be put into category 1 to 3 according to regional or national cost-effectiveness estimates. Further adjustment can be made according to the two other relevant criteria, equity (priority to the worse-off) and financial risk protection. If the service clearly fares well against the additional criteria, it should be placed in the higher priority class. If the service clearly fares less well against those criteria, it should be placed in a lower priority class.

Building on the existing health system structure, essential services will be further specified according to the level of service provision: health post, health center, primary hospitals (inpatient and outpatients), secondary hospitals, and tertiary hospital.

Figure 2. Proposed classification of health services and financing arrangements.



Priority 1 - Exempted services (Free of charge)

- 1A: Current list of exempted services (Essential services with no co-payment)
- 1B: Very cost-effective services that serve the worse-off and provide high financial risk protection (Essential services with no co-payment)

Priority 2 – Cost sharing

- 2A: Cost-effective services that serve the worse-off and provide high financial risk protection (Essential services with low co-payment)
- 2B: Cost-effective services that serve less worse off groups and/or provide less financial risk protection (Essential services with moderate co-payment)

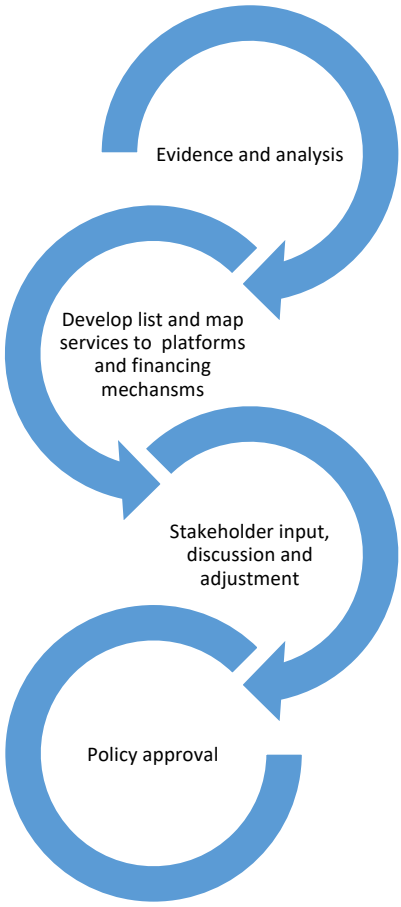
Priority 3 – Cost recovery

- 3A: Not in 1 & 2
- 3B: Non-essential services (cosmetic surgery, etc.)

Process for the revision

Revising Ethiopia's ESHP is an important process for the health sector as it would have health, socioeconomic, and political implications (Figure 3). The process will be led by the Federal Ministry of Health and include Ethiopia's Regional Health Bureaus. The Ministry of Health will need to examine and adopt the recommendations of this paper to prepare a draft, applying the proposed three criteria and using evidence from different sources, taking into account the needs of the population, epidemiology, health system ability to provide services and country ability to pay. Then, this needs to go through robust and participatory consultative processes. As is the case for many other processes, universities, professional associations, the non-state actors, development partners, patient associations and community representatives will be involved. It will then be presented to the highest executive body of the Sector-Executive Committee and the Joint Steering Committees-for policy approval. This process needs a lot of evidence and it is crucial that all the relevant stakeholders actively participate.

Figure 3. Process for Ethiopia's essential health services package revision.



3. Concluding remarks

The revision of Ethiopia's essential health services package will use as much available evidence as possible. Routine system data, disease burden surveys, actuarial studies, national cost-effectiveness studies as well as publications from the Disease Control Priorities 3rd edition project, WHO-CHOICE, and Tufts University CEA registry, and strategic documents like the

HSTP and the Vision 2035 will be some of the sources of data and policy direction that will be explored.

There are two major objectives for improving Ethiopia's path towards UHC: First, the implementation of HSTP, and identifying fair, efficient and cost-effective pathways towards UHC and second, by building capacity at the Ministry of Health in conducting cost-effectiveness analyses, and translating these into policy. Disease Control Priorities–Ethiopia (DCP-E) will be one good source of data for the revision of the services package as envisioned above. With the process established to support health priority setting in Ethiopia, including assessing the burden of disease, evidence of intervention effectiveness, and cost-effectiveness of selected health sector interventions, packages, and platforms, DCP-E will help to provide the investment case for scaling up health interventions, packages and policies toward UHC. These economic evaluations will highlight the health and economic benefits and the equity impact of moving towards UHC for Ethiopia. It will identify critical trade-offs in such a highly resource-constrained setting (e.g. equity vs. efficiency) using all the dimensions of UHC including financial risk protection.

One of the key steps taken to ensure equity in health delivery is instituting a fee waiver system for the poor. Fee waiver is a right conferred to an individual that entitles him or her to obtain health services in facilities at no direct charge or reduced price due to the lack of ability to pay. Through the fee waiver system, the poor will have free access to the EHSP. However, no formal fee waiver policy exists that clearly distinguishes exemption from fee waiver, either in terms of their differing concepts or in terms of their differing applications in practice in the Ethiopian health system. There is no official policy document that recognizes the fee waiver system as yet.

The lack of a formalized policy on fee waiver has resulted in practices that are largely characterized by inconsistent implementation, absence of a clear targeting mechanism, and the presence of multiple 'stakeholders' involved in issuing fee waiver certificates. The fee waiver system will be strengthened to protect the poor from financial barriers in accessing health services. A formal policy and guidelines need to be developed for uniform application (Ethiopia 2005). The fee waiver is in par with the recommendations of the "Making Fair Choices on the Path to UHC" as it addresses two of the three criteria for revising the content: priority to the worse off (equity), and financial risk protection. The full roll out of health insurance will eventually abolish this system as the schemes will have designs to protect the most disadvantaged.

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