

Essential health packages What are they for? What do they change?

Catriona Waddington

June 2013

Essential health packages (EHPs) are frequently promoted as an effective and efficient way of improving health service delivery. There is a recent resurgence in talk about packages, including in the context of universal health coverage, but there are many different interpretations and expectations of what an EHP can deliver.

This paper is a practical aid for people involved in those discussions. It explores the various definitions of EHPs, key design issues and the importance of understanding the context to address implementation challenges. The paper also considers experience of EHPs in different countries and discusses how EHPs can be adapted to different situations.



Main messages

This paper is a practical aid for people involved in discussions about essential health packages (EHPs). This is not a new topic, but there are many different interpretations and expectations of what an EHP can deliver. It is important that debate about packages is clearly articulated and grounded in real experience. The paper focuses primarily on experience with implementation, rather than on the methods for identifying the contents of a particular package.

The role of health packages differs according to the financing context. Packages have a more clear-cut role in insurance systems than in tax-based or aid-dependent health sectors. With insurance, people want to know what services will (and will not) be funded by a particular insurance scheme in return for insurance contributions. Social and community health insurance schemes in effect define an essential health package which is available to all their members. EHPs can be part of the path to universal health coverage because they are about using resources more efficiently.

While the financing context is important, the following key messages generally hold true:

- Essential health packages are a means to concentrate scarce resources on interventions which provide the best value for money. EHPs are often expected to achieve multiple goals: improved efficiency, equity, political empowerment, accountability and more effective care.
- It is important to understand the context in which a particular EHP is being discussed. Some packages are aspirational -they describe what an EHP should eventually look like. Others are seen as a short-term planning tool and are linked more directly to affordability. Packages are most useful if they are understood to be a political instrument rather than a purely technical exercise.
- Packages are defined in different ways. An essential health package in a low-income country often consists of a limited list of public health and clinical interventions which should be provided at primary and/or secondary level care. By contrast, in richer countries, packages are often described according to what they exclude. There are also 'partial packages' for particular disease or demographic groups.
- Essential health packages can help enhance equity - but not on their own. If an EHP is to be universal, or a safety net for the poorest, there must be additional efforts to improve access. Private as well as public providers may need to be involved.
- Implementing an essential health package is not just a technical exercise. Successful implementation involves dialogue on purpose and design; decisions on financing and delivery arrangements; and adaptation over time. Without adequate national ownership, an EHP is unlikely to be implemented - no matter how popular it is with donors.
- Essential health packages are not a solution for weak management. Implementation has implications for budget allocations; essential medicines lists; the distribution and training of health workers; and information systems.

The paper ends with a list of questions to ask when embarking on an EHP.

Introduction

Essential health packages (EHPs) are often promoted as an effective and efficient way of improving health service delivery. There is a recent resurgence in talk about packages, especially at country level, but with many different interpretations and expectations of what an EHP can deliver. It is important that debate about packages is clearly articulated and grounded in real experience. This paper looks at the various reasons for promoting EHPs and their links with wider health sector issues. Essential health package definition and design issues are then outlined. The paper then explores implementation experience with the delivery of EHPs, illustrating points with country examples. One major conclusion is that packages are most useful if regarded as a political instrument, rather than as a purely technical exercise. This paper does not look in detail at the content of specific EHPs. References are provided for readers who want to explore the subject in more depth.

The role of health packages differs according to the financing context. Packages have a more clear-cut role in insurance systems – people want to know what services will (and will not) be funded by a particular insurance scheme. Social and community health insurance schemes in effect define an essential health package which is available to all their members.

1. Why have essential health packages?

Essential health packages are often justified by their potential contribution to high-level goals such as poverty reduction or enhanced equity. In the literature, there are four main types of justification – which may be cited singly or in any combination:

- Priority setting on the grounds of effectiveness and relative cost. Because EHPs generally identify cost-effective interventions, they should increase value for money – for a given level of health spending, the impact on health status should improve. This, along with cost containment, is the most commonly cited rationale for EHPs.
- Equity. Essential health packages are often regarded as promoting equity because they describe a minimum service which should be available to every person with the same need, regardless of their age, gender or location. However, as discussed later in the paper, it takes more than agreement on an essential health package to achieve greater equity.
- Poverty reduction. Because ill-health and paying for health care are major causes of poverty, EHPs can be linked to poverty reduction. Malawi's Essential Health Package is an example.
- Political empowerment and accountability. Because EHPs generally provide a clear description of what services will be available for all, they are a tool for holding governments, providers and insurers accountable. Obviously there is a risk in using this argument, as limiting access to specific services tends to be politically unpopular.

The relative importance attached to these different goals says a lot about the way in which an EHP will be implemented. A primary goal of cost containment is very different from an EHP based on equity, which may entail high-cost expansion of service delivery to previously under-served population groups. It is not unusual for the same EHP to have several, sometimes competing, goals and trade-offs may need to be made.

In real life, more immediate practical concerns may drive the development of an essential health package – for example, it may be seen as a way to define terms of contracts with different sorts of providers, or to set levels of subsidies or insurance reimbursements. EHPs are often seen as a practical tool for improving service delivery because they focus attention on effective interventions, promote good practice and can help clarify the levels at which these interventions should be available.

Resources are never sufficient to meet all health care needs, so some form of prioritizing or rationing is inevitable. An essential health package may assist in this. Other ways to allocate resources include: by a client's ability to pay; by leaving it to clinicians to decide who gets what service; by setting civil service rules about resource allocation – for example, based on the number or location of in-patient beds; or by leaving it to purely political decisions, which may be more influenced by vested interests than any

reference to cost-effectiveness or consideration of the wider population's interests. All can be tested against their contribution (alone or in combination) towards achieving desired health goals.

The above discussion also applies broadly to insurance systems, though the context is different. A key concern of insurance systems is to find a balance between offering services which will attract members and keeping the services (and insurance premia) affordable. Social health insurance (and many community health insurance schemes) also have goals related to equity.

2. Essential health packages: recent history

During the late 1970s and 1980s, EHPs were one aspect of the debate on the merits of a limited package of interventions versus the notion of comprehensive primary health care. EHPs took centre-stage in the debate when the 1993 World Development Report (World Bank) posed a practical question – how should governments in low-income countries spend their very limited health budgets? Using epidemiological and costing data, the Report argued that governments should radically shift their health expenditure from high cost, low benefit interventions towards lower cost, high benefit interventions. The lowest cost, highest benefit interventions combined into a package of essential public health and clinical services. The 2001 Report of the Commission on Macroeconomics and Health subsequently reinforced the importance of packages.

Since the 1993 World Development Report, many middle and low-income countries have adapted the Essential Package idea to their own situations. In some countries this has led to implementation; in others it is more a statement of principle. In many countries, the idea of an EHP has come to prominence as the possibility of introducing social health insurance is explored. Interest in packages is not confined to one particular continent – there are examples from Africa, Asia, Europe and South America.

The 2010 World Health Report *Health Systems Financing: the Path to Universal Coverage* describes three prerequisites for universal coverage – raising sufficient money, raising money through pre-payment mechanisms and spending money more efficiently and equitably. EHPs can be one way of improving efficiency and equity. For example the Report describes how Moldova specified an EHP and then later expanded its scope as part of its overall work to improve access and equity.

3. What is an essential health package?

An essential health package in a low-income country usually consists of a limited list of public health and clinical services which will be provided at primary and/or secondary care level. In contrast, in richer countries, packages are often described according to what they exclude.¹ Essential health packages obviously include different interventions in different countries – reflecting variation in economic, epidemiological and social conditions. Box 1 shows the structure of a package designed in Ethiopia – its contents are broadly typical of a low-income country.

There are also “partial” EHPs for particular demographic or disease groups – examples are EHPs for HIV/AIDS prevention, treatment and care; for mental health; and for maternal, newborn and child health interventions. A package is not necessarily equivalent to a programme: the Integrated Management of Childhood Illness (IMCI) package is an example where an agreed set of priority interventions for child survival is implemented by several programmes (see Table 1 later in the paper).

Many EHPs are intended to be a guaranteed minimum – some clients will have needs which cannot be met by the EHP. With an EHP, the human skills, drugs, equipment and other resources required to deal with interventions within the package should be available. An EHP does not mean that clients with other health problems need to be turned away from health facilities – but there is no guarantee that resources will be available to deal with their particular needs.

¹ Several variations of the term ‘Essential Health Package’ exist, generally using the terms basic, minimum, health care, services or benefit package. For the purposes of this paper, these terms are taken to all mean the same.

Box 1 Ethiopia's Essential Health Services Package (Federal Ministry of Health)

For each of the following broad categories, there are specific interventions to be provided at the health post, health centre and district hospital levels:

- Family health: antenatal care; delivery and newborn care; post-natal care; family planning; child health – Integrated Management of Childhood Illness; growth monitoring and essential nutrition actions; immunization; and adolescent reproductive health
- Communicable diseases: TB and leprosy; HIV/AIDS and sexually transmitted infections; epidemic diseases (including malaria surveillance); rabies
- Basic curative care and treatment of major chronic conditions
- Hygiene and environmental health (N.B. this excludes the provision of mass sanitation and water supplies, which is the responsibility of a different sector)
- Health education and communication

Aspirational EHPs describe a view of what a minimum package should look like. These tend to be used more for “resource mobilization” purposes – at a national or global level. EHPs intended for immediate implementation are more directly linked to short-term affordability, and are more of a rationing package. The context in which a particular EHP document is developed – as a long-term goal or a short-term practical planning tool – clearly influences what is included in the package.

Essential health packages are generally developed using some combination of cost-effectiveness analysis and other technical, political and social considerations. The aim is to concentrate scarce resources on the services which provide the best value for money.

4. Essential health packages: design issues

Essential health packages should be designed to meet their objective(s). The contents of the package need to be specified, and then plans made for how the services will be funded and delivered.

It is widely accepted that the cost-effectiveness of interventions should be one criterion for inclusion in an EHP. It is also generally agreed that cost-effectiveness cannot capture all the relevant considerations – such as societal values and being realistic about implementation. The importance of societal values is clear in decisions such as whether an EHP should include abortion or family planning for under-age women. There is, however, no consensus about a standard method for including considerations other than cost-effectiveness. One possible set of criteria is shown in Box 2 (Gericke et al, 2005).

Box 2 Criteria for specifying the content of an essential health package**Cost-effectiveness:**

- What do various interventions cost?
- How effective are these interventions – what is their impact on the burden of disease?

Feasibility:

- Is a package based on cost-effectiveness politically feasible? Are there contentious inclusions or exclusions?
- Affordability. Having listed interventions in order of cost-effectiveness, how many can be afforded?
- Have the practicalities of implementation been taken into account? (For example, does a particular intervention require extensive inputs from a health worker cadre which is in short supply?)

There is a large literature and much debate about the criteria for specifying the content of EHPs. Issues include:

- The quantity and quality of data. Some consider that collecting all the national data required to inform an EHP is unrealistic. However, not all data need to be collected for all countries. For example, both the Disease Control Priorities Project (<http://www.dcp2>) and WHO's Choosing Interventions that are Cost Effective (CHOICE)² argue that a country can use regional cost-effectiveness information as a first approximation.
- How should political feasibility be incorporated? Value judgements have to be incorporated into EHP design, but there are differences of opinion about how to do this. One way is to have a separate, explicitly political stage which identifies what is and is not politically acceptable. Another is to incorporate value judgements into a multi-criteria decision framework. In Bosnia-Herzegovina, the first method was used – certain interventions were taken as “non-negotiable” for inclusion because they were specified in the 1997 Law on Health Insurance. Other interventions were then ranked according to their cost-effectiveness (Hrabac et al). In Ghana, an exploratory study asked respondents to combine considerations of cost-effectiveness and other issues to prioritize interventions. Some interventions were ranked higher or lower than their cost-effectiveness alone would indicate – for example, improved complementary feeding to prevent childhood under-nutrition was ranked higher when considerations such as the age and income level of the clients were included (Baltussen et al, 2006).

Many countries have used a great deal of money, time and technical assistance to design EHPs. Some perform national cost-effectiveness analyses; many use existing published information to identify cost-effective interventions and concentrate on local costing studies. At the launch of Swaziland's Essential Health Care Package in 2011, for example, the development of the package was described as taking into account:

- “The burden of disease/ill-health of the population of Swaziland
- Cost-effectiveness of the interventions addressing the conditions, diseases and associated factors responsible for the greater part of the disease burden
- Affordability relative to the available and projected resources
- Service delivery models that maximize synergies and linkages” (for example clear pathways for clinical referrals) (WHO).

² <http://www.who.int/choice/en/> CHOICE assembles regional databases on key health interventions and their costs, impact on population health and cost-effectiveness.

Less attention tends to be paid to updating the EHP design – but this is vital, given fast-changing technologies (such as new vaccines), shifts in the burden of disease and changes in available resources. In real life, of course, there can be pressures to introduce new services which are not based on the original logic of a package. Pressure groups have on occasion successfully removed cost-effectiveness entirely from the debate: for example, in the late 1990s, HIV/AIDS activists changed policies on anti-retroviral therapy in many countries by arguing that people's right to treatment transcended considerations of cost-effectiveness.

In addition to the content (or 'scope') of the package, there are also decisions to be made about the level at which the package will be delivered and the 'shape' of the delivery model. EHPs are quite commonly used to help define what services should be provided at which level of care, from community level to tertiary care. Liberia and Mexico are two examples of such approaches (Ministry of Health and Social Welfare Liberia, 2008; Frenk et al, 2006). Having specified the content, there are many possible 'shapes' of delivery model for organizing service delivery. Much depends on existing arrangements. For example, EHP services could be delivered through outreach and/or fixed facility based services; routine services or campaigns; and programmes that focus on a specific sub-set of interventions or facilities that provide an entire primary health care package (and many variants in-between). The private sector could be involved in delivering some or all components of the package. In 2010, the government of Sierra Leone was clear that it needed to involve the private sector in its essential package: "The limitations in the numbers and distribution of government health facilities make it difficult for the Ministry of Health and Sanitation to provide services to the whole of the Sierra Leonean population by itself. For this reason, the Government is giving considerable attention to work out ways whereby the private, not-for-profit and for-profit sectors can become responsible partners in BPEHS's implementation (Basic Package of Essential Health Services)" (Ministry of Health and Social Welfare, Sierra Leone, 2010).

There are also choices to be made about which of the package's interventions can usefully be bundled together. For example, WHO's expanded programme on immunization (EPI) has moved towards a more comprehensive approach that goes beyond immunization to include prevention and treatment of common childhood illnesses, including malaria and pneumonia. This has involved working across multiple programmes. Table 1 shows how child survival interventions were distributed across several programmes (the shaded boxes) in Cambodia. The table also illustrates a second point: an EHP can help identify co-ordination needs between programmes or providers delivering the interventions. For example, aspects of Vitamin A supplementation in Cambodia were handled by IMCI, EPI and the nutrition programme. The need for coordination is clear.

The instruments for translating the notion of an EHP into actual service delivery are discussed later in this paper.

Table 1. Several programmes can implement the same item in an essential health package

Aspects of the EHP related to child survival, Cambodia	Malaria Control Programme	Integrated Management of Childhood Illness	Extended Programme of Immunization	Nutrition Programme	Making Pregnancy Safer
Skilled birth attendance					
Early initiation of breastfeeding					
Exclusive breastfeeding					
Complementary feeding					
Vitamin A supplement					
Measles immunization					
Tetanus toxoid immunization					
Insecticide treated nets					
Oral rehydration therapy					
AB for pneumonia					
Malaria treatment					

5. Essential health packages: setting them within the bigger picture

Essential health packages are developed in many different contexts – understanding the context helps to identify the implementation challenges for a particular EHP. Three questions can help “place” a particular EHP:

5.1 What is the overall health financing context?

In a predominantly tax-financed health service, the EHP generally describes a minimum package of services to be provided by government or government-contracted institutions.

In an insurance-based system, the EHP is generally the minimum package which all insurance policies must cover.

In a health system with mixed financing, the EHP can describe the services which government will provide (or finance) for the uninsured population. In Kyrgyzstan, for example, general tax revenues are pooled to provide a basic benefit package for the whole population. Health insurance contributions entitle contributors to additional benefits. In other countries (Australia for example), tax revenues are mixed with social insurance contributions to ensure access to a package. People are then allowed (and sometimes encouraged) to take out private insurance for additional care.

5.2 Long-term aspiration or short-term affordability?

Is the EHP aspirational or intended for immediate implementation? As mentioned above, the context in which a particular EHP document is developed – as a long-term goal or a short term practical planning tool – clearly influences what is included in the package.

Both the 1993 World Development Report (WDR) and the 2001 Commission on Macroeconomics and Health (CMH) described aspirational minimum packages – a sort of ethical minimum of services which any global citizen should be able to access, but which in practice is currently unaffordable in many countries. The WDR package was costed at \$12 per head for low-income countries (now closer to \$20), while the larger CMH package was estimated at around \$34 per person (now over \$40). Both packages excluded the cost of upgrading the health system to ensure the services could be delivered and excluded interventions such as anti-retroviral treatment for HIV/AIDS - their total costs have thus been under-estimated.

5.3 Aimed at whole population or specific sub-group?

Does the EHP consider the needs of the general population, or is it for a particular group? “Partial” EHPs have been developed for particular disease or demographic groups (e.g. children). The implementation of partial packages poses different challenges than for a full EHP. Partial packages generally deal with only one or two technical programmes and often use resources which have to be shared with other programmes. For example, an EHP describes the priorities for the use of a nurse’s time at a health post; a partial package only deals with some of the responsibilities of that nurse. A risk of partial packages is that they are rarely realistically matched to the total available resources – if all the partial packages in a system were added together, they would most probably cost more than the available resources.

In general, the “big picture” politics of a country has a huge influence on how an EHP is developed and implemented. How are pressures from the élite for high-cost hospital services dealt with? How ‘pro-poor’ and ‘pro-change’ is the government and civil service? In some situations, the decision to establish a minimum package is a sign of a desire for radical change; in other contexts, it can be a delaying tactic, remaining at the discussion and design stage for a long time.

This discussion of context also demonstrates the practical differences between talk of packages (comprehensive or partial) at the global and national levels. At the global level, packages are about advocacy (a recommended course of action). When it comes to implementation, packages pose a number of immediate practical challenges related to human resources, finances, drugs and other resources.

6. Delivering essential health packages: implementation experience

Compared with the large literature on cost-effectiveness and other methods for designing EHPs, literature on how to effectively deliver an EHP is scarce. A few preliminary conclusions can be drawn from the small number of examples which have been adequately documented. This section is organized in two parts - prerequisites for delivering an EHP and adapting EHPs to different situations.

6.1 Prerequisites for delivering an essential health package

Delivering an essential health package requires resources. Implementing an EHP requires either attracting new resources or shifting resources away from some existing interventions, programmes or facilities. To do this, implementation of the EHP needs to be “plugged into” resource allocation decisions and budgeting.

Box 3 Mexico’s essential health package (Frenk et al, 2006)

In 2004, changes to Mexico’s General Health Law formalized the introduction of a package of health reform measures. The reforms included the phasing in, over seven years, of the Seguro Popular, a subsidized insurance scheme offering free access at the point of delivery to an explicit package of health care interventions for the uninsured.

The plan was to cover all uninsured households within seven years. By 2006, 11.5 million individuals were enrolled in Seguro Popular – about 17% of Mexico’s uninsured population. In 2005-6, health service utilization was significantly greater for Seguro Popular members than for the uninsured. Inequalities reduced as Seguro Popular increased coverage in the poorest states and for the poorest income groups.

By 2006, the essential package, which is updated annually, included 249 interventions – this relatively high number reflects Mexico’s status as a middle-income country. The interventions cover ambulatory care, plus hospitalization for the basic specialties.

Interventions for the package were selected by combining burden of disease and cost-effectiveness analyses with other criteria, including affordability, feasibility of implementation and links with catastrophic household expenditure. For example, rotavirus vaccine was excluded until 2006, on the grounds of “un-affordability”, despite evidence of cost-effectiveness ratios which would otherwise have justified its inclusion.

Experts involved in the priority-setting analysis believed that it protected funding for highly cost-effective public health interventions, which are vulnerable because they are less vociferously demanded than many hospital services. The experts also concluded that it was vital to have an institutionalized requirement that cost-effectiveness be demonstrated before any new intervention was added to the package. Without this, it would have been too easy to add new interventions without considering the overall logic of the package.

The introduction of Seguro Popular was complemented by radical reforms in health financing, notably the enhanced importance of federal taxes as a source of health financing (as compared with insurance contributions and state taxes). In addition to this mobilization of funds, a key tool for implementing the package was accreditation of facilities which were able to provide the relevant interventions. Accreditation enabled these facilities to receive Seguro Popular funding. Other practical implementation measures included master plans for new infrastructure, protocols for new interventions and certification procedures for quality assurance programmes.

Box 3 describes how the introduction of the essential package for the uninsured in Mexico was closely linked to major financial reforms. Box 4 describes Afghanistan’s package, which was largely financed by development partners. In Bangladesh, in contrast, the centralized norm-based planning and budgeting system did not change when the essential service package was introduced. District and sub-district budget allocations continued to be determined by norms related to the number of beds (for food and drugs) and staff in post (for salaries). The budgeting system was simply not designed to respond to the demands of the EHP, which required resources to be channelled according to population size and health needs, and to focus largely on ambulatory care. Bangladesh is not the only country to have

encountered problems with funding - in Malawi, only about 57% of the necessary funding to deliver the EHP was available (Bowie and Mwase).

Financial constraints may be more apparent in an insurance system. An insurance system can also send financial signals by setting the level of co-payments. In Bosnia, the least cost-effective services had the highest co-payments (Hrabac et al).

Support systems need to reflect the contents of the EHP. By specifying what interventions will be delivered at what levels of the health system, an EHP has implications for support systems such as human resources, drug supplies, infrastructure and equipment. For example, an appropriate mix of health worker cadres, trained in the appropriate mix of skills, needs to be present at a particular health facility if it is to provide the specified interventions in an EHP. In Sierra Leone, the Basic Package document included details of the diagnostic services, drugs and equipment required to support the package. It even specified the regulatory bodies which were responsible for monitoring standards of service provision. (Ministry of Health and Sanitation, 2010). In Swaziland, the national referral system document, the National Standard Treatment Guidelines and the Essential Medicines List were all launched at the same times as the Essential Health Care Package (WHO).

In Enugu State in Nigeria, the software for the district health information system was adapted to reflect the content of the Minimum Service Package. At the same time, the Package was used to specify facilities' drug requirements. In many countries the national list of essential drugs is clearly linked to the basic health care package. Because drugs lists are a relatively common tool for defining a limited benefit package, they sometimes act as a "quasi-EHP" – effectively limiting what interventions are guaranteed to be available without explicitly describing a whole EHP.

In Malawi, Mueller et al (2011) documented problems in implementing the essential package. There was a shortage of staff due to vacancies but also caused by frequent trainings and meetings (only 48% of expected man days of clinical staff were available; training and meetings represented 57% of all absences in health centres). Moreover despite training, the percentage of health workers aware of vital diagnostic and therapeutic activities related to the essential package was low. Another major constraint was shortages of vital drugs at all levels of facilities (e.g. there was enough Cotrimoxazole in only 27% of health centres). The authors concluded: "greater attention needs to be given to the health system constraints to delivering health care. Removal of these constraints should receive priority over the considerable focus on the development and implementation of essential packages of interventions."

A variety of instruments are needed to move from the design stage to EHP implementation.

There are many possible instruments and approaches, including:

- Clinical or quality assurance protocols, including for referrals
- Contracting providers to provide the essential package
- Regulation and accreditation of individual facilities
- Supervision
- Assigning inputs to meet the needs of the EHP – infrastructure plans, essential equipment lists etc.

In Afghanistan and Cambodia, both public and private service providers have been contracted to deliver a specified package of services. Contracts can describe the services to be delivered in detail and can explicitly link their provision to funding. Box 3 described how the accreditation of health facilities was a key instrument for implementing the package in Mexico.

Of course in real life it is rare to move in a smooth, linear way from EHP design to selecting instruments for implementation. In fact, events may happen the other way round. It may be the imperative to improve supervision of health workers or to develop contracts with NGOs in under-served areas (as examples) which drives the development of an EHP.

If the EHP is to be universal, or a safety net for the poorest, there must be deliberate efforts to improve access. In many low-income countries, access to good-quality health care is limited and patients face high out-of-pocket expenditures, often for ineffective treatments. Simply making an EHP available is not enough – utilization needs to be actively monitored to ensure that an EHP is achieving its objectives. In Uganda, the minimum package did not significantly change the fact that 70% of the population did not use a minimum-package provider (government or mission) as their first point of call

when ill (Ssengooba). In Afghanistan, both private and public providers were involved in delivering the basic package, and careful monitoring has been used to identify groups with poor access (Hansen et al, 2008).

Box 4 Afghanistan's Basic Package of Health Services (Hansen et al, 2008)

In 2003, the Ministry of Public Health in Afghanistan developed a Basic Package of Health Services (BPHS). The BPHS specified services for basic and comprehensive health centres and district hospitals. It was complemented by an Essential Package of Hospital Services for other hospital care.

Much of the delivery of the BPHS was contracted out to NGOs and financed by international development partners – contracts covered about 75% of the population in 2005. Contracts were then worth about \$5 per person per year (an extremely basic package), excluding the transaction costs of managing and monitoring the contracts.

To monitor implementation, a 'Balanced Scorecard' was developed. The Scorecard had 29 indicators organized into six domains – patients and community; staff; capacity for service provision; service provision; financial systems; and overall vision.

Indicators measured issues such as how TB treatment was monitored; the functionality of laboratories; whether salaries were paid on time; fee exemptions for poor clients; and the percentage of new out-patients who were female. The Scorecard was used on a wide scale – every year from 2004-7 it was used in a random sample of more than 600 health facilities, 1,700 health workers and 5,800 patient-provider interactions.

Information provided by such rigorous monitoring allowed regular adjustments to be made to the way in which the Package was implemented. A future challenge is to incorporate aspects of the Scorecard into routine supervision.

Although it demonstrates the uses of relevant information, the Afghan experience has been largely driven by international funding and expertise.

Implementing an EHP is not just a technical exercise – political and institutional processes need to be engaged. If an EHP is developed with inadequate ownership from politicians and/or senior Ministry of Health management, it is unlikely to be implemented. This is a particularly pertinent point because many donors like EHPs – they are generally tangible, evidence-based and costed.

Bobadilla (1998) described examples from Mauritius and Andhra Pradesh, where EHP development was in the hands of relatively disengaged foreigners and academics respectively, and – at least at the time of the review in 1998 – there had not been progress beyond defining the package (Bobadilla and Cowley, 1995; Bobadilla, 1998). Technical people developing an EHP need to engage with political and institutional processes from an early stage. A technical group working in relative isolation from core MoH functions will not be able to influence the decisions related to HR and supplies which are vital at the implementation stage.

"Bangladesh has had an Essential Service Package (ESP) since the late 1990s. Progress with implementation has been faltering for a number of reasons, including rigidities in the use of the government budget in the provider facilities; poor oversight on which elements of the ESP were actually being delivered; and the fact that some elements of the ESP fell under the National Directorate of Health Services while others fell under the Directorate of Family Planning. Many Ministry of Health and Family Welfare staff saw the ESP as essentially a donor-driven exercise which involved just a few Ministry personnel. Implementation of the ESP was not a systematic guiding principle for decisions related to budgets, the staffing of facilities or monitoring. Such joined-up decision-making is crucial for the successful implementation of an essential health package (Ensor et al, 2002; Martin and Reza, 2007)." This point is further reinforced by a recent WHO review: in some countries where an EHP has been developed, and a specific document exists, the EHP is not mentioned in other key policy documents such as the Poverty Reduction Strategy Papers, the Medium-Term Expenditure Framework or even the national health policy document. In other countries, the EHP is much more prominent and

consistently mentioned across all key policy documents, and seems to be used as the basis for discussions on budgets, staffing and other decisions (Porignon).³

In some circumstances, an EHP can change the mindset of health planners. The Ethiopian EHP document states that one of the advantages of the EHP is that it shifts the attention of health planners away from inputs, towards services and outputs. In practical terms, this has meant moving away from counting the number of facilities and the population living nearby, towards counting the number of facilities providing the essential package to an acceptable standard and the level of utilization of these services. In Uganda, discussions about packages helped to bring together decisions about public health and clinical services (Box 5).

Box 5 The Minimum Package in Uganda – a health planner’s perspective (Kadama)

The Declaration of Alma Ata in 1978 influenced the Ugandan Ministry of Health’s (MoH) subsequent five-year plans – their scope broadened from clinical services alone to the full primary health care package. However, funds were short and debate about a more limited package soon began – though the cost-effectiveness debate did not really influence discussions until the 1990s.

In the 1990s, Uganda piloted a Minimum Health Care Package (MHCP). The World Bank funded district burden of disease and cost-effectiveness studies, which formed the basis for district plans and pilots for implementation in eight districts. It proved politically impossible to continue work with just eight districts, and the pilots were ultimately abandoned. Nevertheless, the development of the MHCP helped the Ministry of Health attract additional funding from donors and from the Ministry of Finance, which was impressed by the MoH’s systematic identification of need. The MoH considered that a long-term view was needed for complete implementation of even this ‘minimum’ package: its initial target date was 2018. The MHCP also helped to structure discussions and resource allocation in the health sector wide approach. All new funds attracted went to primary level facilities, while funds to higher-level facilities were held constant.

Introduction of the MHCP involved dialogue on concept and design, and negotiations on financing and delivery arrangements. It raised difficult human resource issues related to task-shifting. These had to be managed sensitively, as there was a risk of losing professional support for the MHCP. The professional associations agreed to support community health workers as a temporary measure to implement the MHCP up to 2012 – on the condition that the output of trained nurses was increased at the same time. The MHCP was also a useful platform from which to discuss service delivery with programmes – for example, it influenced the debate about the ultimate closure of stand-alone leprosy and TB services.

For many years, the Minimum Package remained centre stage in MoH planning documents but many programmes found alternative funding from Global Health Initiatives, which distorted the package’s overall financing.

6.2 Adapting essential health packages to different situations

Essential health packages can be delivered with or without user fees. User fees for health care are a controversial issue – this paragraph just highlights the relevance of the topic in the context of EHPs, without discussing it in detail. Fees deter some utilization, but at the same time the income from fees can be vital for effective service delivery. Many EHPs do involve fees (or co-payments in insurance systems) for at least some users – for example, Egypt and Afghanistan. The challenge in such countries is to design fee structures and exemptions which do not deter utilization by vulnerable groups and for priority services. In Egypt, calculations of the cost of scaling up the family health basic benefit package included an estimate that 20% of funds would result from cost recovery. An exemptions policy existed, but was applied inconsistently. Despite being specified in the policy, some governorates did not exempt children under five years old; others did not exempt patients with certain specified chronic illnesses (Unger and Kamel, 2005).

³ Preliminary findings from a WHO analysis in 20 countries with explicit EHPs, which compared the consistency in what is said about the same EHP across different policy documents in the same country.

Essential health packages can be adapted to reflect different conditions in different parts of a country. For example, in federal Ethiopia, Regional Health Bureaux can adapt the Essential Health Services Package to reflect epidemiological differences (such as the presence or absence of malaria) and/or different local priorities.

Essential health packages can work well in some fragile states. It can be easier to introduce a package after a period of very little service delivery, rather than shifting resources in an existing system (which involves curtailing some services). The case of Afghanistan (Box 4) illustrates that EHPs can be an effective device in some post-conflict situations – when service provision has become weak and fragmented, donor funding is available, and there is political will to improve access to basic services. The instruments for implementing delivery of the package were also well-developed, with a particular reliance on contracting. Of course EHPs will not necessarily work well in all fragile states. Fragile states which are chronic under-performers may not be able to deliver the joined-up decision-making (related to human resources, supplies etc.) which is necessary for the implementation of an essential health package.

7. Conclusions

Packages are most useful if they are understood to be a political instrument, rather than a purely technical exercise. They can support the progressive realization of primary health care. Their development can help to promote dialogue on health priorities, and structure negotiations on who should deliver what and where, in order to get better value for money.

An essential health package cannot be developed in isolation from practical considerations of implementation, because it has implications for the way services are organized, for management support systems and for funding. The role of an EHP in social insurance, for example, is not the same as in a predominantly tax-funded system.

By being explicit, packages can – at least in theory – help to improve accountability. This requires monitoring in order to see if progress is being made towards the intended goals of the EHP.

The following questions can be asked when embarking on the development of an essential package.

- Why do we want an essential health package? What is it going to be used for? Who is expected to benefit? If we want currently under-served populations to benefit, are we being realistic that they will be able to access the new EHP?
- How will we specify the contents and cost of the EHP? What work needs to be done? Who should be involved in its development?
- What timeframe are we talking about in terms of achieving implementation?
- Which providers are expected to implement the EHP? How will they be supported? What changes need to be made to budget allocations, training and distribution of health workers, medicines lists, reporting forms, etc?
- How will the EHP be financed? Are new resources needed, or will resources be shifted away from existing programmes or facilities? What is the plan if the costing vastly exceeds current resources?
- Monitoring implementation: how will this be done? Who will review the results? Who is responsible for taking action when needed?

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About the author

Catrina Waddington is a health economist in HLSP, with particular expertise in health systems and development co-operation effectiveness. She has worked extensively on health systems strengthening.