

## ESSENTIAL HEALTH PACKAGES: WHAT ARE THEY FOR? WHAT DO THEY CHANGE?

### Main messages

This Technical Brief is intended as a practical aid for people involved in discussions about Essential Health Packages. This is not a new topic, but there are many different interpretations and expectations of what an EHP can deliver. This Brief focuses primarily on experience with implementation, rather than on design methods. The following key messages can be drawn from the literature.

- Essential health packages aim to concentrate scarce resources on interventions which *provide the best 'value for money'*. By doing this, EHPs are often expected to achieve multiple goals: improved efficiency; equity; political empowerment, accountability, and altogether more effective care.
- EHPs are intended to be a *guaranteed minimum*. An EHP in a low-income country consists of a limited list of public health and clinical interventions which will be provided at primary and/or secondary level care. In 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 enhance *equity*. However, if an EHP is to be universal, or a safety net for the poorest, there must be additional deliberate efforts to improve access. Private as well as public providers may need to be involved.
- It is important to *understand the context* in which a particular EHP is being discussed. Some packages are aspirational - and describe what an EHP should eventually look like. Others are seen as a short term planning tool, and linked more directly to affordability.
- Implementing an EHP is *not just a technical exercise*. Political and institutional processes need to be engaged, because 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 Brief ends with a list of questions to ask when embarking on EHP work.

## 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. Having defined the term, this Technical Brief looks at the various reasons for promoting EHPs and their links with wider health sector issues. EHP design issues are outlined and alternatives to EHPs discussed. The Brief then moves on to explore implementation experience with the delivery of EHPs, illustrating points with country examples. This Brief 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.

## What is an EHP?

An Essential Health Package in a *low-income* country 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.<sup>1</sup> EHPs obviously include different interventions in different countries – reflecting variation in economic, epidemiological and social conditions. Box 1 shows the structure of Ethiopia’s package, which is 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 a good example in which an agreed set of priority interventions for child survival are implemented by several programmes (see box x).

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.

### Box 1 Ethiopia’s Essential Health Services Package

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: ante-natal care; delivery and newborn care; post-natal care; family planning; child health – Integrated Management of Childhood Illness (IMCI); growth monitoring and essential nutrition actions; immunization; adolescent reproductive health
- Communicable diseases: TB and leprosy; HIV/AIDS and sexually transmitted infections; epidemic

<sup>1</sup> 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 Brief, these terms are taken to all mean the same.

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

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'.

## EHPs: recent history

During the late 1970s and 1980s, Essential Health Packages 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 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 towards spending on a minimum package of essential public health and clinical services. The Report of the Commission on Macroeconomics and Health (2001) and the 2006 Disease Control Priorities Project 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. Interest in packages is not confined to one particular continent – there are examples from Africa, Asia, Europe and South America.

### **Box 2 The Minimum Package in Uganda – a health planner's perspective**

The Declaration of Alma Ata in 1978 influenced the Ugandan Ministry of Health's 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 of district plans and pilots for implementation in 8 districts. It proved politically impossible to continue work with just 8 districts, and the pilots were ultimately abandoned. Nevertheless, the development of the MHCP helped the Ministry of Health attract additional funding from the Ministry of Finance - impressed by the MoH's systematic identification of need, and from donors. 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 SWAp. 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 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.

In recent years, the Minimum Package remains centre stage in MOH planning documents but many programmes have found alternative funding from Global Health Initiatives, which has distorted the package's overall financing. *Source: P Kadama, 2008*

## Why have Essential Health Packages?

EHPs are often justified by their potential contribution to high-level goals such as poverty reduction or enhanced equity. 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.
- *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.
- *Equity.* EHPs are generally regarded as equitable, because they describe a minimum service which should be available to every person with the same need, regardless of their age, gender or location.
- *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 government, providers and insurers accountable. Obviously there is a risk in using this argument, as limiting access to specific services tends to be politically unpopular.

In addition to these links with high-level goals, 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.

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.

## EHPs: design issues

Having established the objectives of an EHP, there are three things to think about: its contents and how it will be delivered and financed.

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 3. (Gericke)

### **Box 3 Criteria for specifying the content of an EHP**

#### ***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 the data requirements to be unrealistic. However, not all data needs to be collected for all countries. For example, both the Disease Control Priorities Project and WHO's CHOICE<sup>2</sup> 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. (Hrabač) 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

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<sup>2</sup> CHOICE assembles regional databases on key health interventions and their costs, impact on population health and cost-effectiveness.

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)

- *Considering interventions in isolation from each other is artificial.* Modelling techniques can deal with the inter-dependence of interventions and interventions can be clustered into natural groupings such as “complete package of family planning options”.

Many countries have used a great deal of money, time and technical assistance to design EHPs. Some do national cost-effectiveness analyses; many use existing published information to identify cost-effective interventions and concentrate on local costing studies. Less attention is often paid to updating 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 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 level care. Liberia and Mexico are two examples.

Having specified the content, there are many possible 'shapes' of delivery model for organising 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.

There are also choices to be made about which of the package's interventions can usefully be bundled together. For example, WHO's EPI programme 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. The question of how far to go in bundling or 'integrating' delivery of interventions is discussed further in Technical Brief 1. Table 1 shows how child survival interventions were “bundled” across programmes in Cambodia. **To be inserted.** This table also illustrates a second point: an EHP can help identify coordination needs between programmes or providers delivering the interventions.

Various management tools – or EHP “vehicles” - exist to engage private and public providers in delivering an EHP. Some are listed on page 10.

## **EHPs: setting them within the bigger picture**

EHPs 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:

- **Long-term aspiration or short term affordability?** Is the EHP aspirational or intended for immediate implementation? Aspirational EHPs describe a view of what a minimum package *should* look like. These tend to be used more for “resource mobilization” purposes - at 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.

Both the 1993 World Development Report and the Commission on Macroeconomics and Health 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 about \$16), while the larger CMH package was estimated at around \$34 per person.

- 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. It may describe the services which have to be provided without co-payment.
  - In a *health system with mixed health 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.
- **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 (children, for example). 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.

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.

## Alternatives to EHPs

If we accept that prioritizing and rationing are inevitable because resources will never be sufficient to meet all the health care needs of a country, then decisions have to be made in some way about how to allocate resources. When considering the advantages and disadvantages of EHPs, it is worth being explicit about the alternatives:

- *Follow the client's money.* A client receives a particular service if s/he can pay for it out of pocket or afford an insurance package which will later pay for the service. Out of pocket expenditures can influence access even when an EHP is in place if official or unofficial fees prevent some clients from accessing EHP services.
- Leave it to *clinicians*. Provide evidence-based clinical protocols and guidelines, but allow clinicians some leeway in responding to individual clinical presentations. This is promoted as a practical way of dealing with the fact that clients turn up at health facilities with a variety of health issues, some well-defined and within an EHP, others not.
- Follow *civil service rules*. Civil services often have established rules for resource allocation, based on norms (e.g. the budget allocated according to the location of in-patient beds) or formula (for example to allocate the budget amongst regions).
- Purely *political* decisions, without reference to cost-effectiveness. Depending on the political system, these decisions may reflect narrow vested interests or some level of consideration of the wider population's interests.

We saw above that EHPs can be linked to specific goals such as poverty reduction and greater equity. Alternatives to EHPs can be tested against their contribution to similar explicit goals.

## Delivering EHPs – implementation experience

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

### Prerequisites for delivering an EHP

- ***Delivering an EHP 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 4 describes how the introduction of the essential package in Mexico was closely linked to major financial reforms. Box 5 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.

Financial constraints may be more apparent in an insurance system – indeed pressing budgetary considerations may drive the creation of an EHP. 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. (Hrabač)

#### **Box 4 Mexico's essential health package**

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 7 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.

The plan was to cover all uninsured households within 7 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.

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).

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.

In addition to mobilizing additional 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. *Source: Lancet series on Mexican health reforms*

- **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 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.

- **Effective "vehicles" are needed for EHP implementation** Once an essential package has been specified, and resources secured, "vehicles" need to be identified to ensure that the package is actually provided by facilities. Possibilities include:
  - Clinical or quality assurance protocols, including for referrals.
  - Contracting providers to provide the essential package.
  - The 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 4 describes how the accreditation of health facilities is a key tool for implementing the package in Mexico.

- **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 and mission) as their first point of call when ill,

because of inadequate coverage or perceived low quality. (Ensor, Ssengooba). In Afghanistan, private as well as public providers were involved in delivering the basic package, and careful monitoring has been used to identify groups with poor access (Box 5).

**Box 5 Afghanistan's Basic Package of Health Services (Hansen)**

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 6 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 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 - there had not been progress beyond defining the package. Technical people developing an EHP need to engage with the 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. One reason is institutional – the ESP lacked an

institutional home within government which “owned” the ESP and was committed to its implementation. Many Ministry of Health and Family Welfare staff saw the ESP as essentially a donor-driven exercise which involved just a few Ministry staff. 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; Martin and Reza). 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 review has found that the EHP is not mentioned in other key policy documents such as the PRSP, the MTEF 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<sup>3</sup>.

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 utilisation of these services. In Uganda, discussions about packages helped to bring together decisions about public health and clinical services. (Kadama)

## Adapting EHPs to different situations

- ***EHPs can be delivered with or without user fees*** User fees for health care are a controversial issue – 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)

- ***EHPs can be adapted to reflect different conditions in different parts of a country*** EHPs 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

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

to reflect epidemiological differences (such as the presence or absence of malaria) and/or different local priorities.

- **EHPs can work well in some fragile states** The case of Afghanistan (Box 5) 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.

EHPs will not necessarily work well in all fragile states, however. Fragile states which are chronic under-performers may not be able to deliver the joined-up decision-making (related to HR, supplies etc.) which is necessary for the implementation of an EHP.

## Conclusions

Packages are most useful if regarded as a political instrument, rather than as a purely technical exercise. 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 organised, for management support systems and for funding.

By being explicit, packages can - at least in theory - help to improve accountability. This requires monitoring - 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 are 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 define it? Cost it? 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?

## Further Reading and References (do same numbering system as for Brief 1)

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