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# ESSENTIAL PACKAGES OF HEALTH SERVICES IN 24 COUNTRIES FINDINGS FROM A CROSS-COUNTRY ANALYSIS

**June 2017**

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USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this six-year, \$209 million global project increases the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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**Submitted to:** Scott Stewart, AOR  
Jodi Charles, Senior Health Systems Advisor  
Office of Health Systems  
Bureau for Global Health

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*Photo:* Malaria Prevention Program July 2011 | Zambia.  
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Abt Associates Inc. | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814  
T: 301.347.5000 | F: 301.652.3916 | [www.abtassociates.com](http://www.abtassociates.com)

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |  
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# ESSENTIAL PACKAGES OF HEALTH SERVICES IN 24 COUNTRIES FINDINGS FROM A CROSS-COUNTRY ANALYSIS

This report is the first in a series on essential packages of health services in low- and middle-income countries. The series is available at <https://www.hfgproject.org/ephs-epcmd-country-snapshots-series/>

## **DISCLAIMER**

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# ACRONYMS

|              |  |
|--------------|--|
| <b>AIDS</b>  | Acquired Immune Deficiency Syndrome                |
| <b>EPCMD</b> | Ending Preventable Child and Maternal Deaths       |
| <b>EPHS</b>  | Essential Package of Health Services               |
| <b>DTP3</b>  | Diphtheria Tetanus Toxoid and Pertussis            |
| <b>HFG</b>   | Health Finance and Governance Project              |
| <b>HIV</b>   | Human Immunodeficiency Virus                       |
| <b>RMNCH</b> | Reproductive, Maternal, Newborn and Child Health   |
| <b>USAID</b> | United States Agency for International Development |
| <b>WHO</b>   | World Health Organization                          |

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# INTRODUCTION

Every country has finite resources for providing health care to its citizens. Policy makers are faced with a need to determine where to target limited resources.

Explicitly prioritizing certain health care services and technologies can enable low- and middle-income countries to reach key development and public health goals (Glassman et al 2016). Certain health care interventions generate greater positive outcomes than others, which in turn lead to improvements in a country's poverty, disease, or inequity burden. Such interventions may be prioritized because they are highly cost-effective or of moral importance, as is generally the case for maternal, newborn, and child health care interventions, among others.

Once policy makers define priority services, they also must ensure that the services are available to all who need them. The World Bank's seminal 1993 World Development Report concluded that "governments have a fundamental responsibility for ensuring universal access to an essential package of clinical services, with special attention to reaching the poor."

Governments employ different mechanisms to define priority services and ensure that the services are available to all who need them. One mechanism is through an essential package of health services (EPHS). A second mechanism is through a publicly funded health benefit plan (HBP), such as a social health insurance scheme. An EPHS represents a broad policy statement, while an HBP specifies an explicit set of services and the cost sharing requirements for beneficiaries to access those services. Both mechanisms can be considered incremental measures to move towards universal health coverage. However, further investigation is needed to determine the extent to which EPHSs and HBPs align and how they are formulated, modified, and implemented.

This study was performed in two parts. The first part involved an analysis of EPHSs from the United States Agency for International Development's 24 Ending Preventable Child and Maternal Deaths (EPCMD) countries.<sup>1</sup> It resulted in 24 country snapshots, each of which serves as a resource to policy makers, researchers, and the international community at large. Each snapshot identifies the contents of the country's EPHS; provides context for how the EPHS contributes to governance of the health sector; and presents an analysis of the extent to which priority reproductive, maternal, newborn and child health (RMNCH) interventions are represented in the EPHS. The snapshots summarize key findings on how the government aims to improve access to the EPHS by priority or vulnerable populations, how the government makes the EPHS physically and financially available to its citizens, and the status of health equity in the country.

The second part of the study involved a comparison of the EPHS and the major HBP(s) in each of the 24 countries, where relevant. These comparisons are presented in briefs for 17 countries that fit the study's inclusion criteria.

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<sup>1</sup> At time of part I of the study, the Ending Preventable Child and Maternal Deaths countries were: Afghanistan, Bangladesh, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, and Zambia.



The qualitative data gathered for this study provided a basis for the cross-country comparative analysis presented in the following sections. The analysis highlighted broad themes related to how governments use the EPHS and related policies and programs to improve health service delivery and health outcomes. These data also highlight cross-country trends about the degree of alignment in the services included in an EPHS versus those covered under HBPs.

## What is an essential package of health services?

An EPHS is a list of clinical and public health services that a government has determined as priority for the country. It is often published in a national-level policy document such as a Health Sector Strategic Plan or similar document, although there are many exceptions to this rule among the countries we studied. According to the World Health Organization (WHO 2008), EPHSs “aim to concentrate scarce resources on interventions which provide the best 'value for money'. By doing this, [essential packages of health services] are often expected to achieve multiple goals: improved efficiency; equity; political empowerment, accountability, and altogether more effective care.”

We used the following definition of an EPHS for the purpose of identifying those services that best represented the country's EPHS:

**The EPHS comprises those health care services that the government is providing or is aspiring to provide to its citizens in an equitable manner. Equity involves equal coverage across population groups, adequate physical access to services for all, and adequate financial protection, particularly for the poor.**

No single EPHS is appropriate for every country. Countries vary with respect to disease burden, level of poverty and inequality, moral code, social preferences, operational challenges, financial challenges, and so on. Weighing the cost-effectiveness of different services within a specific context is one way of prioritizing health care interventions, but governments also consider political, technical, or social factors when setting priorities (WHO 2008).

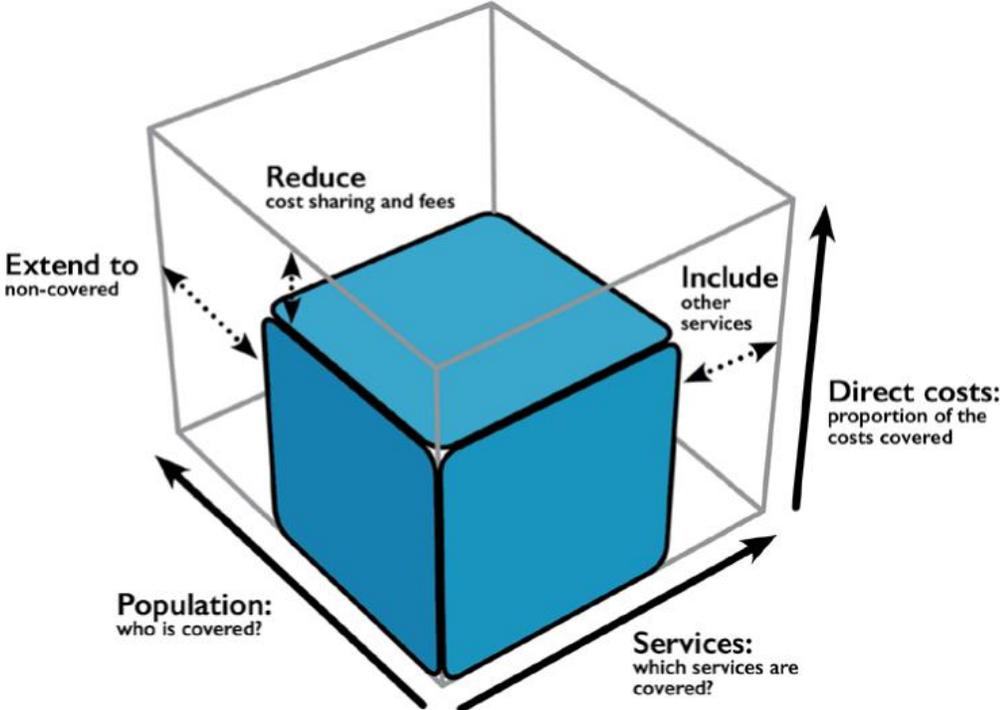
## What is a health benefit plan?

We used the following definition of an HBP as proposed by the Inter-American Development Bank (2014) for purposes of this study:

**Health benefit plans are health programs that, a) have a minimum set of explicit guarantees, b) are financed with public resources, and c) are linked to the needs or social preferences of the population to be covered.**

EPHSs and HBPs are closely related to the concept of universal health coverage. The World Health Organization (WHO) defines three core dimensions of universal coverage (Figure 1): services covered, proportion of costs covered, and population covered. An EPHS and an HBP, as statements of the government's priority services, also need to consider the two other dimensions. Programs and policies established to support EPHS or HBP implementation often involve improving physical and financial access to services for priority and vulnerable populations. The EPHS and/or HBPs may be one of several mechanisms or the main mechanism for a country to move toward universal health coverage.

**FIGURE 1: THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE**



Source:WHO 2015



# METHODOLOGY

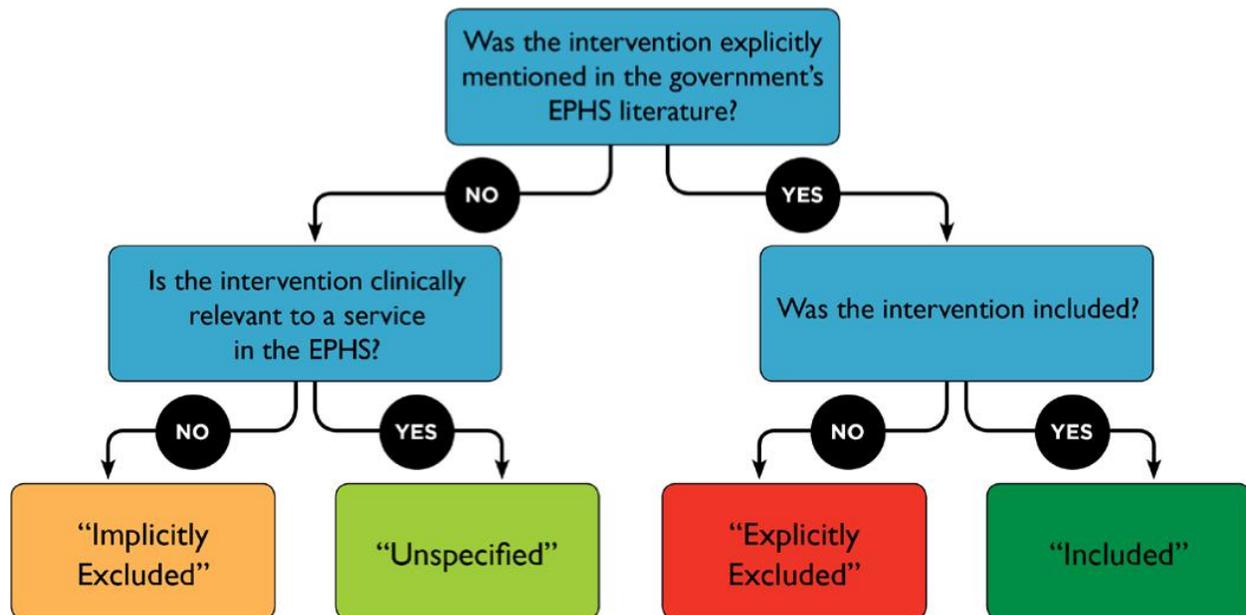
To inform the study, the Health Finance and Governance (HFG) Project reviewed primary sources (e.g., government policy documents) and secondary sources (e.g., peer-reviewed articles, international reports, and gray literature) to identify the country’s EPHS and describe the service coverage, population coverage, mode of health services delivery, and financial coverage of the country’s EPHS. This review took place between August 2014 and December 2015. HFG then reviewed primary and secondary sources to identify and collect information on significant, publicly funded health benefit plans in each country. This subsequent review took place between May and August 2016.

## Service coverage of the EPHS

We described the service coverage of the country’s EPHS in three ways. First, HFG identified the actual list of services included in the government’s EPHS. This information was presented in an annex of each country snapshot.

Second, HFG evaluated the extent to which a country’s EPHS included RMNCH interventions by comparing each country’s EPHS to the list of 60 priority RMNCH interventions proposed by the Partnership for Maternal, Newborn and Child Health (PMNCH 2011). We developed and applied an algorithm to categorize how each of the 60 priority RMNCH interventions relates to the country’s EPHS (Figure 2).

**FIGURE 2: ALGORITHM USED TO CATEGORIZE THE 60 PRIORITY RMNCH INTERVENTIONS**



The comparison between a government’s EPHS and the priority RMNCH interventions should be interpreted with caution. Priority RMNCH interventions tend to be more specific than those in an EPHS. For example, an EPHS may include “prevention of pre-eclampsia” or “antenatal care,” but the priority intervention is “low-dose aspirin to prevent pre-eclampsia.” In this case, the intervention would fall into the “unspecified” category because while it is clinically related to the general service in the EPHS, the documentation did not specify that health workers should use low-dose aspirin. Some governments have published clinical standards and guidelines that provide this level of detail. As available, we used the most detailed documentation published by the government to confirm whether health workers are guided to provide the particular intervention.

Third, to describe service coverage, where available we used key RMNCH indicators from the Global Health Observatory<sup>2</sup> that quantify the extent to which certain RMNCH services are available and used in a country. Indicators include:

- ▶ Pregnant women sleeping under insecticide-treated nets (%)
- ▶ Births attended by skilled health personnel (in the five years preceding the survey) (%)
- ▶ BCG immunization coverage among one-year-olds (%)
- ▶ Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among one-year-olds (%)
- ▶ Median availability of selected generic medicines (%)—private
- ▶ Median availability of selected generic medicines (%)—public.

## Population coverage, service delivery, and financial protection of the EPHS

We described population coverage of the EPHS by identifying the sub-populations targeted by the government for improved access to the EPHS. For example, a national government may identify a specific initiative to improve adolescents’ access to the EPHS.

We also obtained and presented key findings from the Health Equity Country Profile for each country, when available.<sup>3</sup> The Profiles lend insight into the country’s population coverage of the EPHS because the Profiles stratify health services utilization information by certain sub-populations (e.g., place of residence, sex, age, and wealth). Health Equity Country Profiles were not available for Afghanistan or South Sudan.

We reviewed relevant literature to describe the mode of delivery of services included in the EPHS. This information is to provide context and reference information on how the government has incorporated the EPHS into the country’s health service delivery system.

We identified national and sub-national initiatives aimed at reducing financial barriers to access the EPHS. One example of an initiative is the reduction or elimination of user fees for services included in the EPHS.

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<sup>2</sup> <http://www.who.int/gho/en/>

<sup>3</sup> [http://www.who.int/gho/health\\_equity/countries/en/](http://www.who.int/gho/health_equity/countries/en/)

## Alignment of service coverage between the EPHS and HBP(s)

HFG identified significant HBP(s) in each study country. We then compiled information about each significant HBP's design features and identified the list of services covered by the plan, where explicitly stated. We included HBPs that are fully or partially publicly financed and that employ risk pooling to provide financial protection to beneficiaries when accessing covered services. For the HBPs with an identifiable explicit list of covered services, we "cross-walked" the list of covered services to the services listed in the country's EPHS. This comparison allowed us to determine which services aligned and which did not, placing particular focus on RNMCH services. We reviewed each service that was 1) included in the EPHS and/or the HBP; or 2) explicitly excluded from the EPHS and/or the HBP. We classified each service using the classification system in Table 1.

We also noted the HBPs for which we could not identify an explicit list of covered services.

**TABLE 1: CLASSIFICATION SYSTEM FOR THE CROSSWALK ANALYSIS**

| Service included in EPHS matches service included in HBP                            |   |
|---|---|
| Service included in HBP fits within a broader category of services included in EPHS | Service included in EPHS fits within a broader category of services included in HBP |
| Service included in EPHS but not included in HBP                                    | Service included in HBP but not included in EPHS                                    |
| Service explicitly excluded from EPHS   | Service explicitly excluded from HBP  |



# FINDINGS

To our knowledge, HFG’s study is the most comprehensive review to date of EPHS and HBPs adopted by governments of low-income countries. In this section we first present findings from a cross-country analysis of EPHSs, then present findings from a cross-country analysis of the alignment between the EPHS and the HBPs in a given country.

We found that 23 of the 24 countries in the review have defined an EPHS. The one exception is the Government of Mozambique, which does not have an EPHS that fits our definition but recently committed to developing one. Also, only one of Pakistan’s four provinces (Punjab) has defined an EPHS; we considered that EPHS as Pakistan’s EPHS for purposes of this study. Eighteen of the 24 governments have adopted an official name for their EPHS and the names vary. For example, Ethiopia’s government refers to its EPHS as “Essential Health Services Package for Ethiopia,” while Mali calls its EPHS the “*Paquet Minimum d’Activité*” (Minimum Package of Activities).”

Several countries—Ghana, Madagascar, Senegal, Yemen, and Zambia—define essential services in multiple policy documents rather than packaging them under one umbrella term.

We found that 17 of the 24 countries had both an EPHS and at least one significant HBP. For 10 of those countries, we were able to identify a list of services covered by the HBP with sufficient detail to cross-walk it to the EPHS.

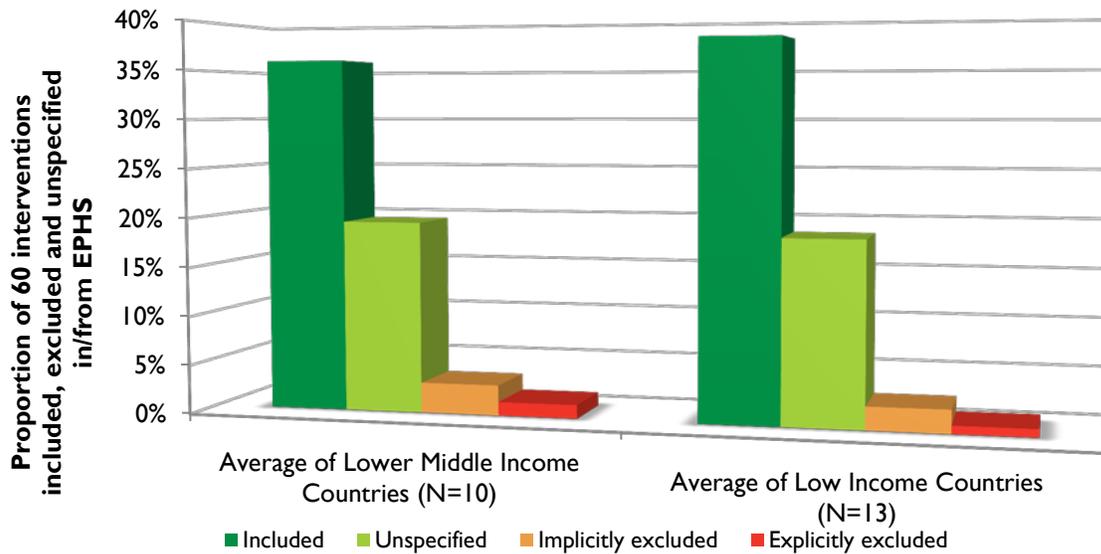
## Cross-cutting themes

### ***In general, a majority of priority RMNCH interventions are represented in EPHS.***

Figure 3 shows the proportion of priority RMNCH interventions categorized as *included*, *unspecified*, *implicitly excluded*, or *explicitly excluded* (refer to Figure 2 above for category definitions).

Most governments included a majority of the RMNCH interventions in the EPHS, as depicted in dark green. The light green represents the large portion of unspecified interventions—those that were clinically related to the services included in the EPHS, but not specified at that level of detail. A small minority of the priority RMNCH interventions were not included in the EPHS, either implicitly or explicitly.

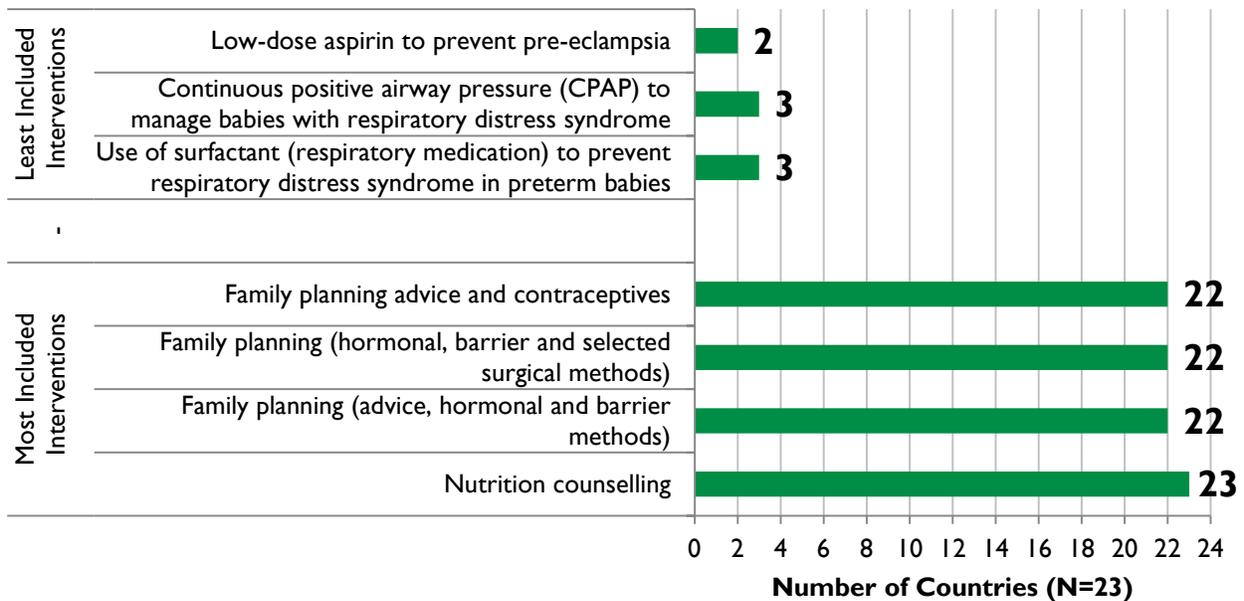
**FIGURE 3: EVIDENCE OF RMNCH INTERVENTIONS IN EPHS**



*Certain interventions are rarely found in an EPHS, while others are found frequently.*

Figure 4 depicts the interventions that were least often categorized as included in the EPHS and the interventions that were most often categorized as included. It is important to note that these findings depend in part on the specificity of the intervention under review. Alone, this analysis does not provide sufficient information to determine which interventions are the lowest and highest priorities of national governments.

**FIGURE 4: INTERVENTIONS MOST AND LEAST OFTEN INCLUDED IN EPHS**



For example, the intervention least often categorized as included in the EPHS is “low dose aspirin to prevent pre-eclampsia (for adolescents and pre-pregnancy).” This highly specific intervention is unlikely to be mentioned in a national policy document. In contrast, the intervention most often categorized as included in the EPHS reviewed is “nutrition counseling.” Relative to many others, this is a broad intervention.

**Interventions related to certain service or disease areas are frequently included in EPHS.**

Annex A includes a series of figures depicting the representation of priority interventions, grouped by service or disease area.

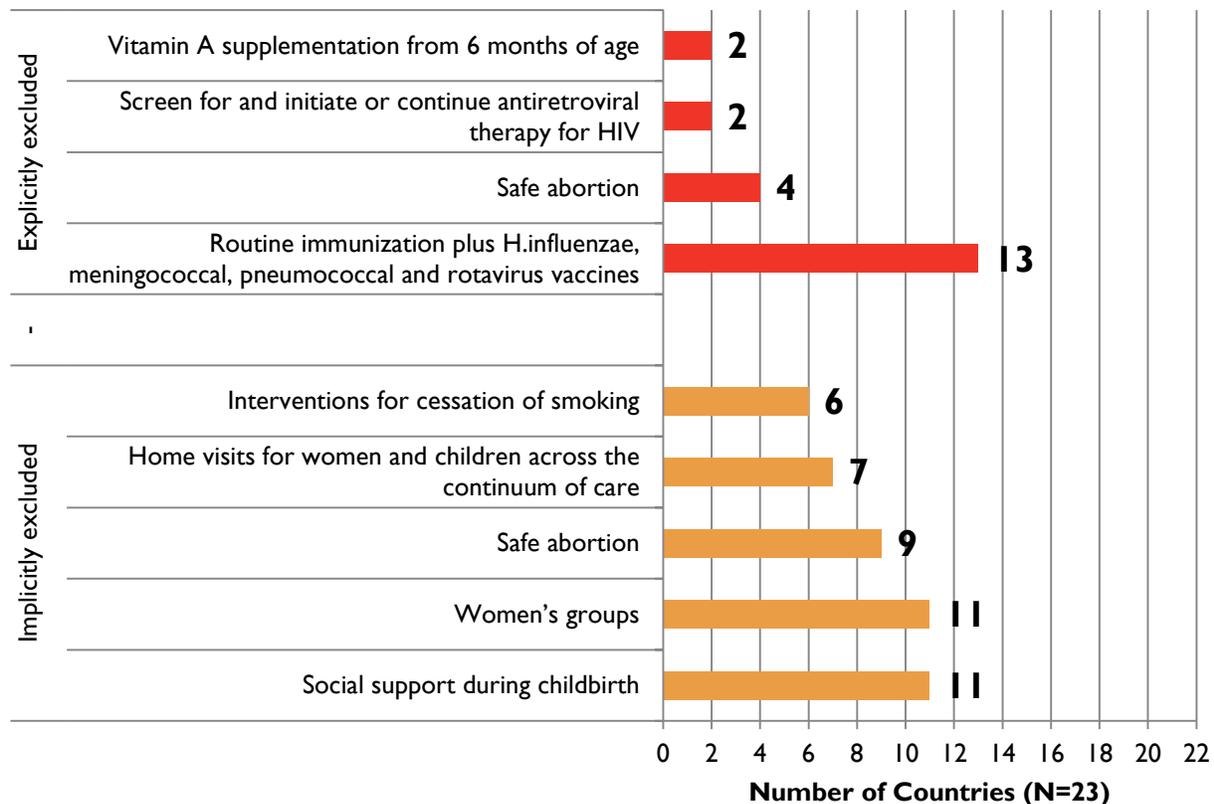
In general, family planning interventions are well represented in EPHS across countries. Interventions to prevent and manage maternal infections are least represented in EPHS, in part because those interventions tend to be defined very narrowly.

**Certain interventions are frequently excluded from an EPHS, either explicitly or implicitly.**

Figure 5 depicts the interventions that were most often categorized as *explicitly excluded* from the EPHS and those that were most often categorized as *implicitly excluded* from an EPHS.

As stated previously, it is important to note that these findings partially depend on the specificity of the intervention under review. Alone, this analysis does not provide sufficient information to determine which interventions are the lowest priorities of national governments.

**FIGURE 5: INTERVENTIONS MOST OFTEN EXCLUDED FROM EPHS**



### ***Governments use similar service delivery mechanisms to deliver the EPHS to their citizens.***

In reviewing the modes of EPHS delivery in all 23 countries with an EPHS, we found that governments use similar service delivery mechanisms. Most governments deliver EPHS services primarily through public sector primary care and referral facilities. Many also use community health workers to expand access to hard-to-reach and marginalized populations.

### ***Governments seek to expand access to the EPHS for priority and vulnerable population groups through policies and initiatives related to EPHS.***

The governments of the 23 countries with an EPHS specified strategies to improve access to the EPHS for priority sub-populations, such as women, adolescents, rural populations, and the indigent. In its EPHS document and accompanying literature, Nigeria's government targets the following groups for improved geographic and financial access to the EPHS: pregnant women, children under five, orphans, and the elderly.

Bangladesh's EPHS and accompanying operational plans include specific strategies to improve care provision for the following sub-populations: the hard-to-reach, the disadvantaged or poor, urban, newborns, children, adolescents, women, people with disabilities, the elderly, and HIV and AIDS patients.

### ***Governments seek to provide financial protection through policies related to the EPHS.***

All governments we reviewed provided some financial protection, but specific initiatives and the extent of their use varied. Financial protection initiatives include:

- ▶ Social health insurance (for civil servants, formal sector employees, informal sector employees, the indigent, and more)
- ▶ Government-sponsored or subsidized community-based health insurance
- ▶ User fee exemptions (for some or all of the services included in the EPHS).

### ***Governments use the EPHS for a range of practical governance applications.***

Our review of policy documents showed that different governments appear to use the EPHS for different health sector governance purposes. There does not seem to be one central policy objective that fits the EPHS profile in every country.

Some governments use the EPHS for health sector stewardship or for guiding private sector service delivery. For example, in Afghanistan, health service provision is through non-governmental organization facilities.

The government intends to use the EPHS as a means of setting standards for provision of care across all providers. Similarly, in Zambia, the government signed agreements with Churches Health Association of Zambia facilities to provide the services in the EPHS in areas not adequately covered by a public facility, and uses the EPHS as a means of setting standards.

Governments use the EPHS to promote accountability among health care facilities and facility staff by specifying which services should be available across the system. India’s government, for example, uses its EPHS (also known as the Indian Public Health Standards) in this way.

Other governments use the EPHS as a planning tool for improving population coverage, increasing financial protection or improving certain factors that affect service delivery. The Liberian government’s EPHS is an example of an EPHS that serves a planning and implementation function.

***In general, an EPHS lists more services than an HBP.***

In most countries in the study, the list of services comprising the EPHS is longer than the list of services covered by an HBP in the same country. Table 2 lists the 16 cases (country /HBP combinations) we cross-walked to the country’s EPHS.

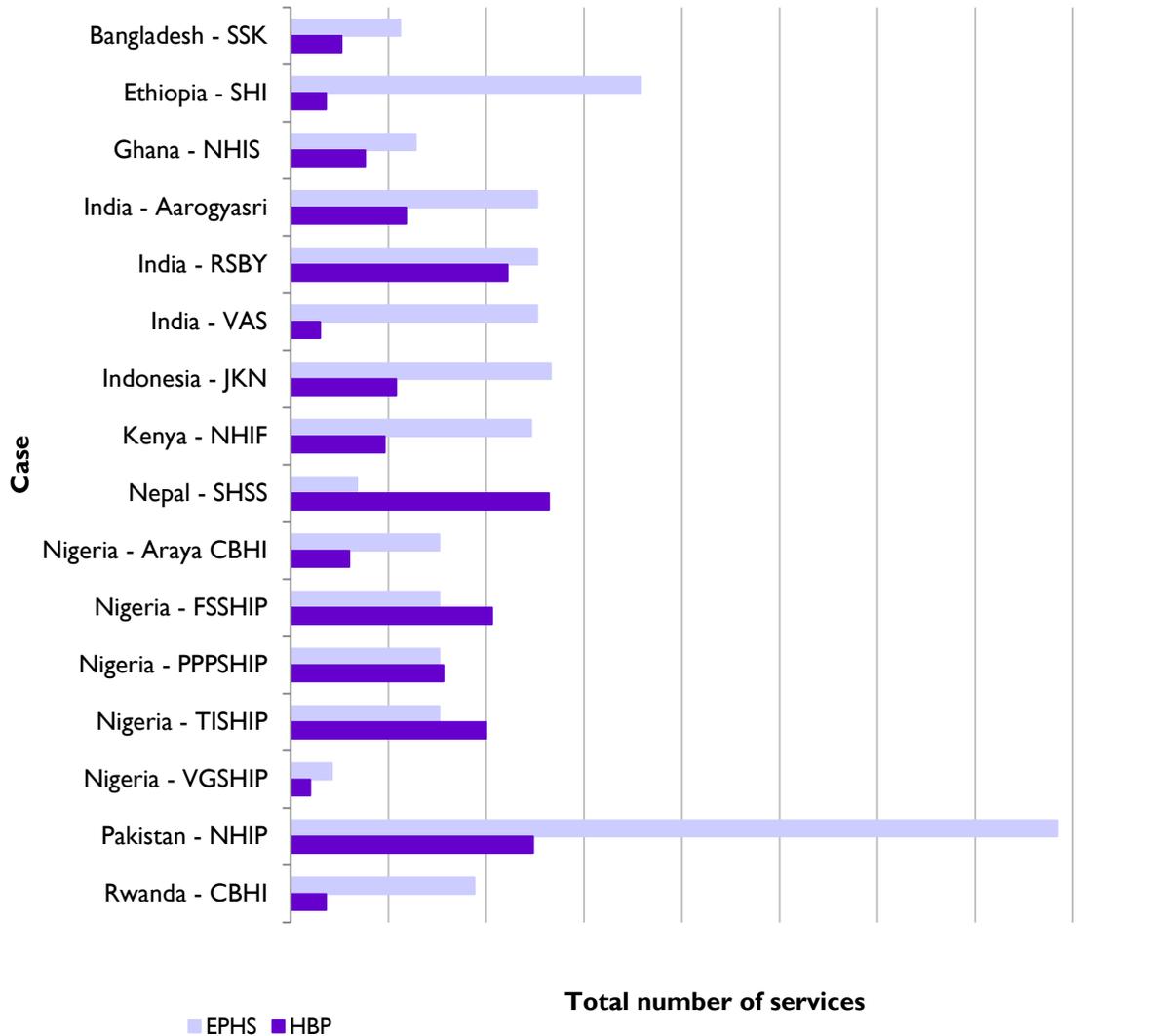
**TABLE 2: HBPs CROSS-WALKED TO THE COUNTRY’S EPHS**

|   |  |
|---|--|
| Bangladesh – Shasthyo Surokhsha Karmasuchi (SSK)  | Nepal – Social Health Security Scheme (SHSS)   |
| Ethiopia – Social Health Insurance (SHI)  | Nigeria <ul style="list-style-type: none"> <li>• Araya Community Based Health Insurance Scheme (Araya)</li> <li>• Formal Sector Social Health Insurance Program (FSSHIP / VGSHIP / VCSHIP)</li> <li>• Public Primary Pupils Social Health Insurance Program (PPPSHIP)</li> <li>• Tertiary Institutions Social Health Insurance Program (TISHIP)</li> <li>• Vulnerable Group Social Health Insurance Program for Children Under 5 (VGSHIP)</li> </ul> |
| Ghana – National Health Insurance Scheme (NHIS)   |  |
| India <ul style="list-style-type: none"> <li>• Aarogyasri Community Health Insurance Scheme (Aarogyasri)</li> <li>• Rashtriya Swasthya Bima Yojana (RSBY)</li> <li>• Vajpayee Arogyashree Scheme (VAS)</li> </ul> |  |
| Indonesia – Jaminan Kesehatan Nasional (JKN)  | Pakistan – National Health Insurance Program (NHIP)  |
| Kenya – National Hospital Insurance Fund (NHIF)   | Rwanda – Community based health insurance (CBHI)   |

Figure 6 compares the absolute number of services included in the EPHS with those included in the list of services covered by the HBP(s). In Nigeria and India, we identified and cross-walked more than one HBP.

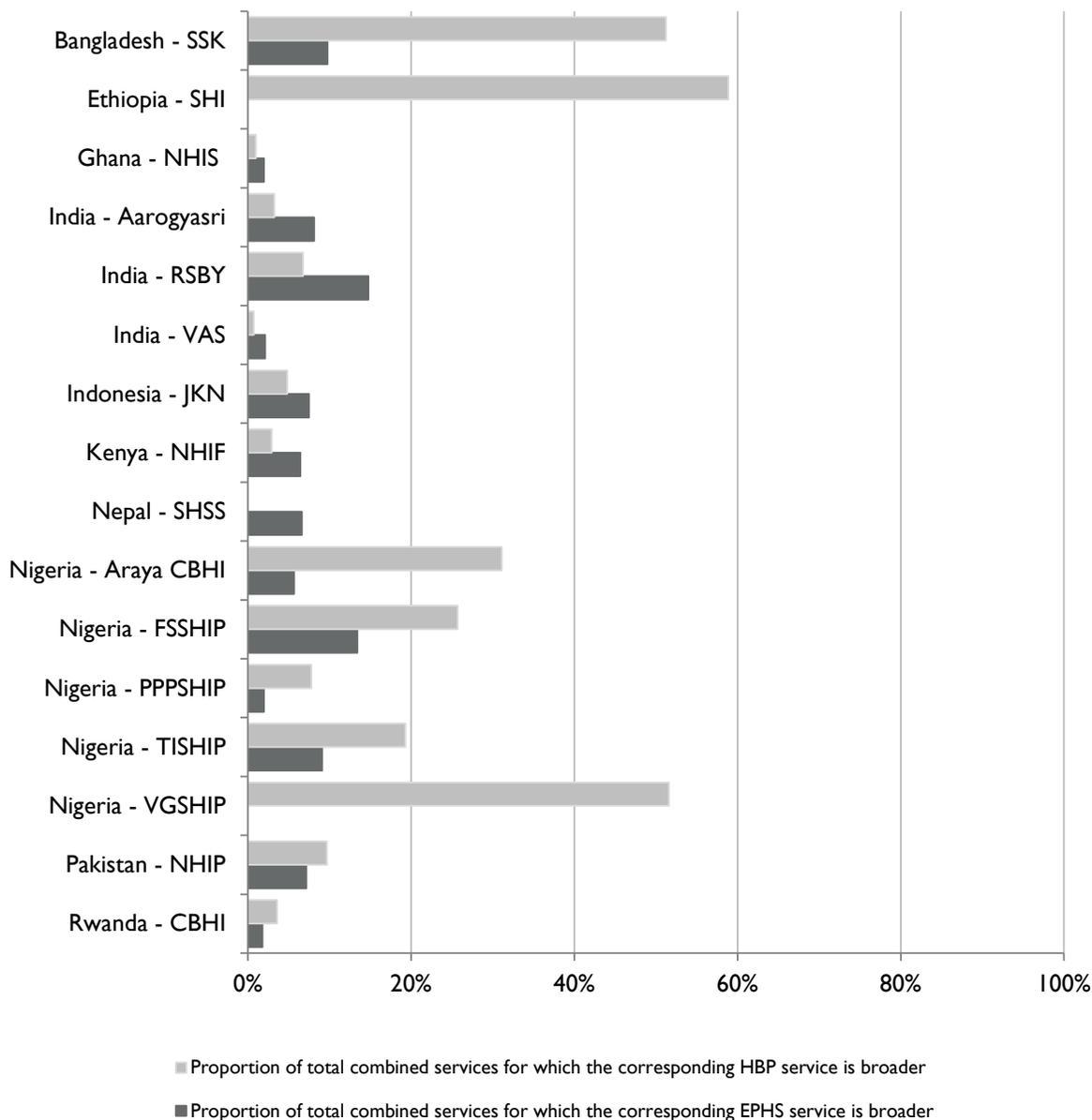
The EPHS contained a longer list of services in 12 of the 16 country /HBP combinations. The four exceptions were for Nepal’s Social Health Security Scheme, Nigeria’s Formal Sector Social Health Insurance Program, Nigeria’s Public Primary Pupils Social Health Insurance Program, and Nigeria’s Tertiary Institutions Social Health Insurance Program.

**FIGURE 6: NUMBER OF SERVICES INCLUDED IN EPHSs AND HBPs**



Contrary to reasonable assumption, longer EPHSs are not explained by EPHSs being more granular and detailed compared with the list of services covered by HBPs. In fact, for almost half of the cases we classified more EPHS services as broader than the corresponding HBP service (see Figure 7).

**FIGURE 7: SPECIFICITY OF SERVICES IN EPHSS AND HBPS**

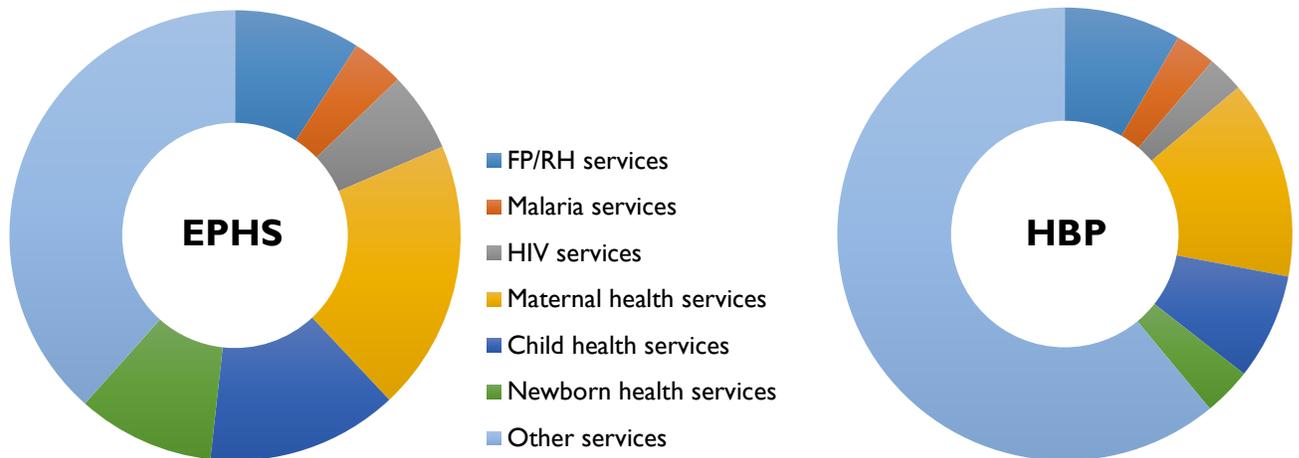


For example, the service, “counseling clients for family planning” noted in Kenya’s HPB was more specific than the corresponding EPHS service, “family planning.” To aid comparison of the results in Figure 7, the denominator for each proportion is the total combined EPHS and HBP services in that country.

**RMNCH services make up a larger proportion of services in EPHSs than in HBPs.**

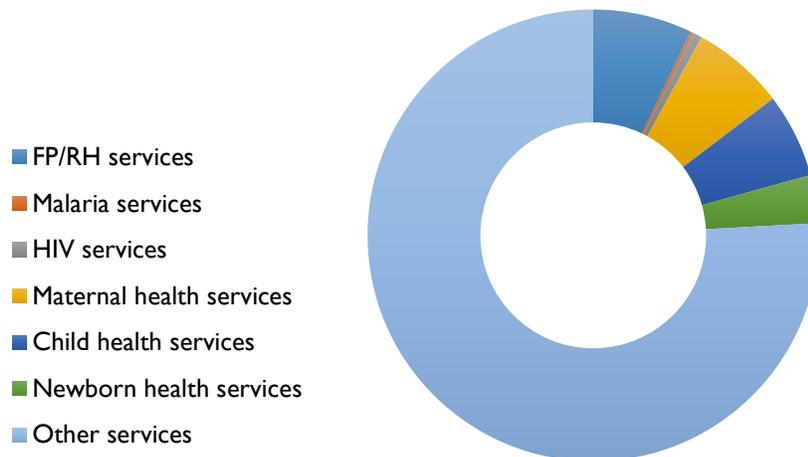
We analyzed the categories of services included in the EPHSs and the HBPs and found that the composition of services by category differs. Figure 8 shows that on average, the EPHSs include a larger proportion of all the major RMNCH service categories as well as a larger proportion of malaria and HIV services. The HBPs include a larger proportion of services that fall under the “Other” category. This category includes services such as treatment of non-communicable diseases, laboratory services, and many secondary and tertiary services like surgeries

**FIGURE 8: COMPOSITION OF EPHS AND HBP SERVICES BY CATEGORY (WEIGHTED AVERAGE ACROSS 16 CASES)**



The “other services” under the HBP tend to be services that are not included in the EPHS. Figure 9 shows the breakdown of services that are included in an HBP but are not included in the EPHS of the same country. “Other services” is by far the largest category proportionally.

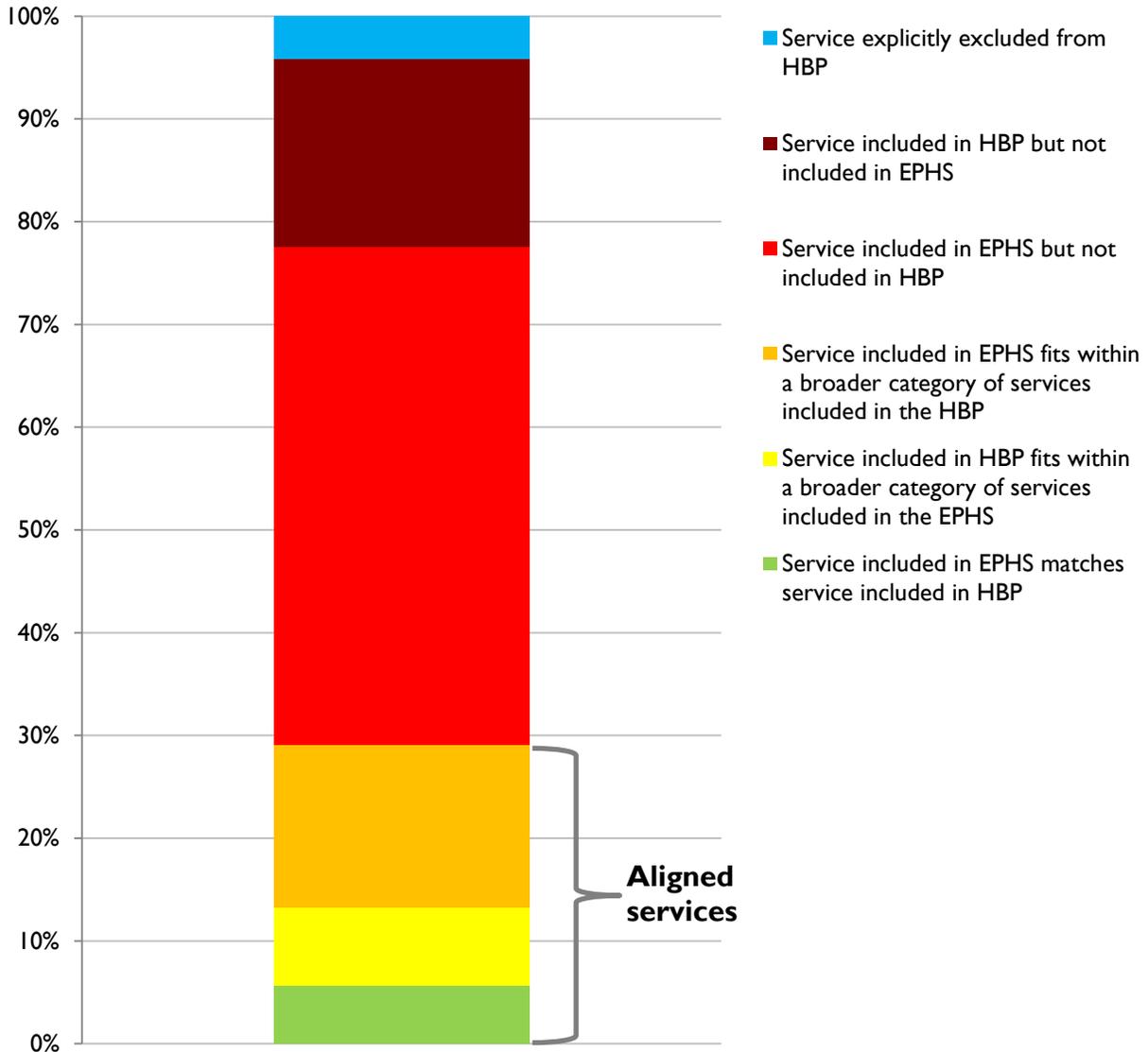
**FIGURE 9: COMPOSITION OF SERVICES INCLUDED IN THE HBP BUT NOT INCLUDED IN THE EPHS (WEIGHTED AVERAGE ACROSS 16 CASES)**



**Overall, alignment between EPHSs and HBP lists of covered services is limited.**

We reviewed every service of the EPHS and cross-walked it to a corresponding service in the HBP. We did the same in reverse. The purpose of the exercise was to identify the degree of alignment between the services included in the EPHS and those covered by the HBP. Figure 10 shows a breakdown of the services by category. When we include those services that match directly between the lists, as well as those that map to a broader category on the other list, still less than 30% of services align between EPHSs and HBPs.

**FIGURE 10: ALIGNMENT OF SERVICES BETWEEN EPHSs AND HBPs  
(WEIGHTED AVERAGE ACROSS 16 CASES)**





An EPHS is a package of health care services that the government is providing or is aspiring to provide to its citizens in an equitable manner. An EPHS, published by a national government, can be an important and in some cases bellwether policy document and governance tool for the health sector. Most low- and lower middle-income country governments in our study have published an EPHS; some have gone through several revisions over the decades. The governments in our study usually specified the EPHS in a policy document that governs the health sector, such as a Health Sector Strategic Plan.

The findings from our study suggest that the concepts of EPHS and universal health coverage are linked, albeit not always explicitly. The process of defining an EPHS and building operational initiatives around it can help governments expand service coverage, population coverage, and financial protection for a set of prioritized services. But our study also found that the process of development and implementation of an EPHS varies between countries, and a government's policy objectives for the EPHS are not always explicit. Many governments struggle to provide the full service package. In response, governments design separate initiatives aimed at promoting access to and use of health services for certain populations.

Using the EPHS as a means of truly defining the essential services in that country, while at the same time ensuring a strong and explicit link between the EPHS and other health sector initiatives such as HBPs, will help governments streamline their major health systems strengthening efforts. However, this study shows that there is limited alignment in service coverage between EPHSs and the significant HBPs in the same country. EPHSs usually list more primary health services (including many RMNCH services) than an HBP in the same country, whereas the largest category of services under HBPs is usually "other" which includes many secondary and tertiary care services.

This finding provides further evidence that an EPHS serves a different purpose than an HBP. Where an EPHS is a government's policy mechanism for defining basic, primary care services to be delivered in public health facilities, the HBP is a health financing mechanism that provides financial protection to enrollees for services across the care continuum that they need or demand. However, our study is limited in that it does not assess cost effectiveness, or impact on disease burden, of services included in an EPHS or in an HBP. Therefore, this study cannot draw conclusions on the effectiveness or impact of a country's EPHS relative to an HBP in the same country or across countries.

The study design does allow one to measure relative transparency of HBPs. Study findings show that while information about basic design features of HBPs may be available in the public domain, the list of services covered by the plan was not always available. A lack of publicly available information has implications for transparency of the scheme. People who enroll in a risk pooling mechanism like a social health insurance scheme have a right to know the benefits they are entitled to receive in exchange for the premium paid by them or on their behalf.

Once an EPHS and an HBP is defined, policy makers and program managers have the difficult job of ensuring the services are actually available to and accessed by the population in an equitable manner. While the translation from policy to implementation looks different in every country, there are several ways policy makers can fulfill the promise of the EPHS and an HBP. Policy makers might seek to align major health sector initiatives with the EPHS. They might promote the EPHS or the HBP to health care workers by incorporating its policies and objectives directly into trainings, clinical standards documents, and others. Ministries of Health and Finance might use the EPHS framework as a reference point to optimize health sector resource distribution and budgeting.

An EPHS and a list of services covered by an HBP is an output of a priority-setting exercise, but work cannot stop there. Policy makers and program managers need to take concrete steps to ensure that the EPHS and the HBP serve their ultimate purpose: access to essential services.

## SOURCES

Amanda Glassman, Ursula Giedion, Yuna Sakuma, and Peter C. Smith (2016) Defining a Health Benefits Package: What Are the Necessary Processes?, *Health Systems and Reform*, 2:1, 39-50, DOI: 10.1080/23288604.2016.1124171

Partnership for Maternal, Newborn and Child Health. 2011. *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn, and Child Health (RMNCH)*. Geneva.

World Bank. 1993. *World Development Report. Investing in Health*. Washington, DC.

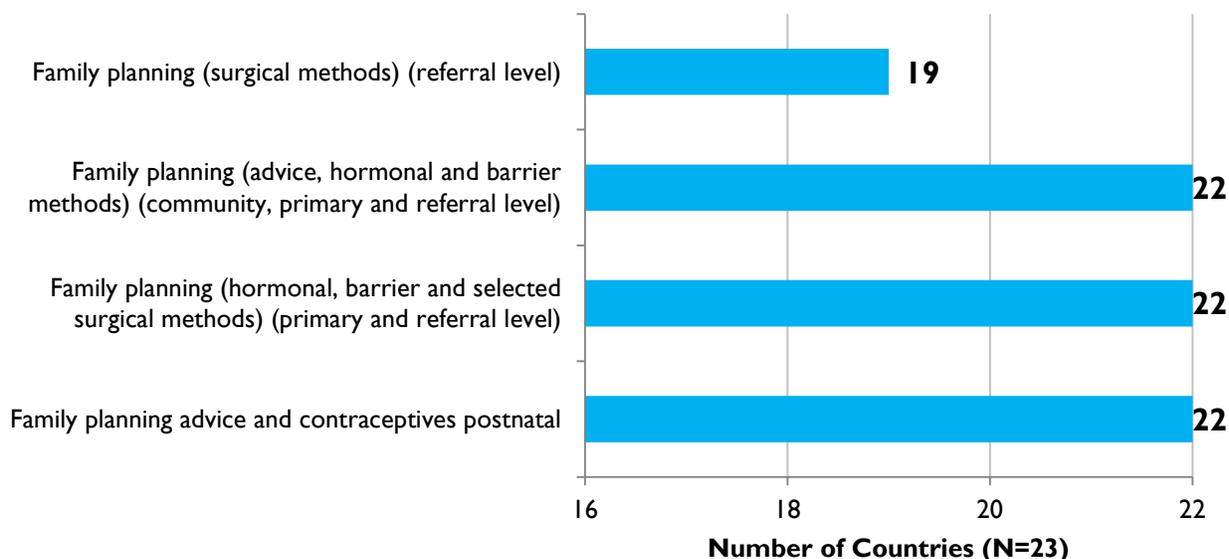
World Health Organization. 2008. Essential Health Packages: What are they for? What do they change? DRAFT Technical Brief No. 2, 3 July. WHO Service Delivery Seminar Series. [http://www.who.int/healthsystems/topics/delivery/technical\\_brief\\_ehp.pdf](http://www.who.int/healthsystems/topics/delivery/technical_brief_ehp.pdf). Accessed June 2014.

World Health Organization. 2015. "Universal coverage—three dimensions." Webpage. [http://www.who.int/health\\_financing/strategy/dimensions/en/](http://www.who.int/health_financing/strategy/dimensions/en/). Accessed December 2015.

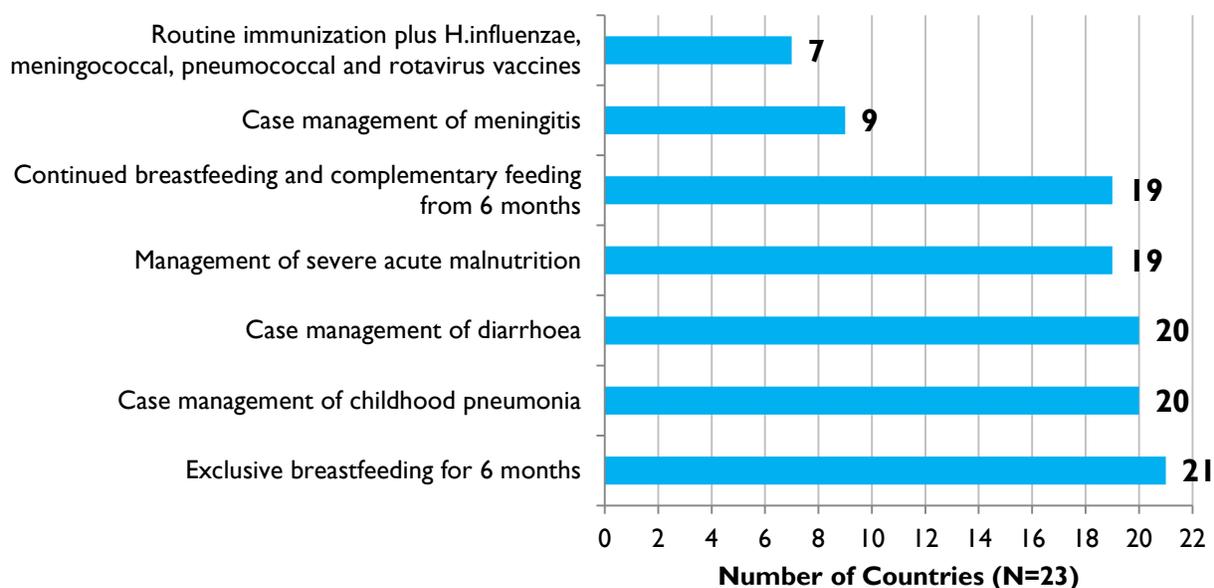


Figures depicting number of countries including interventions in EPHS, grouped by service or disease area

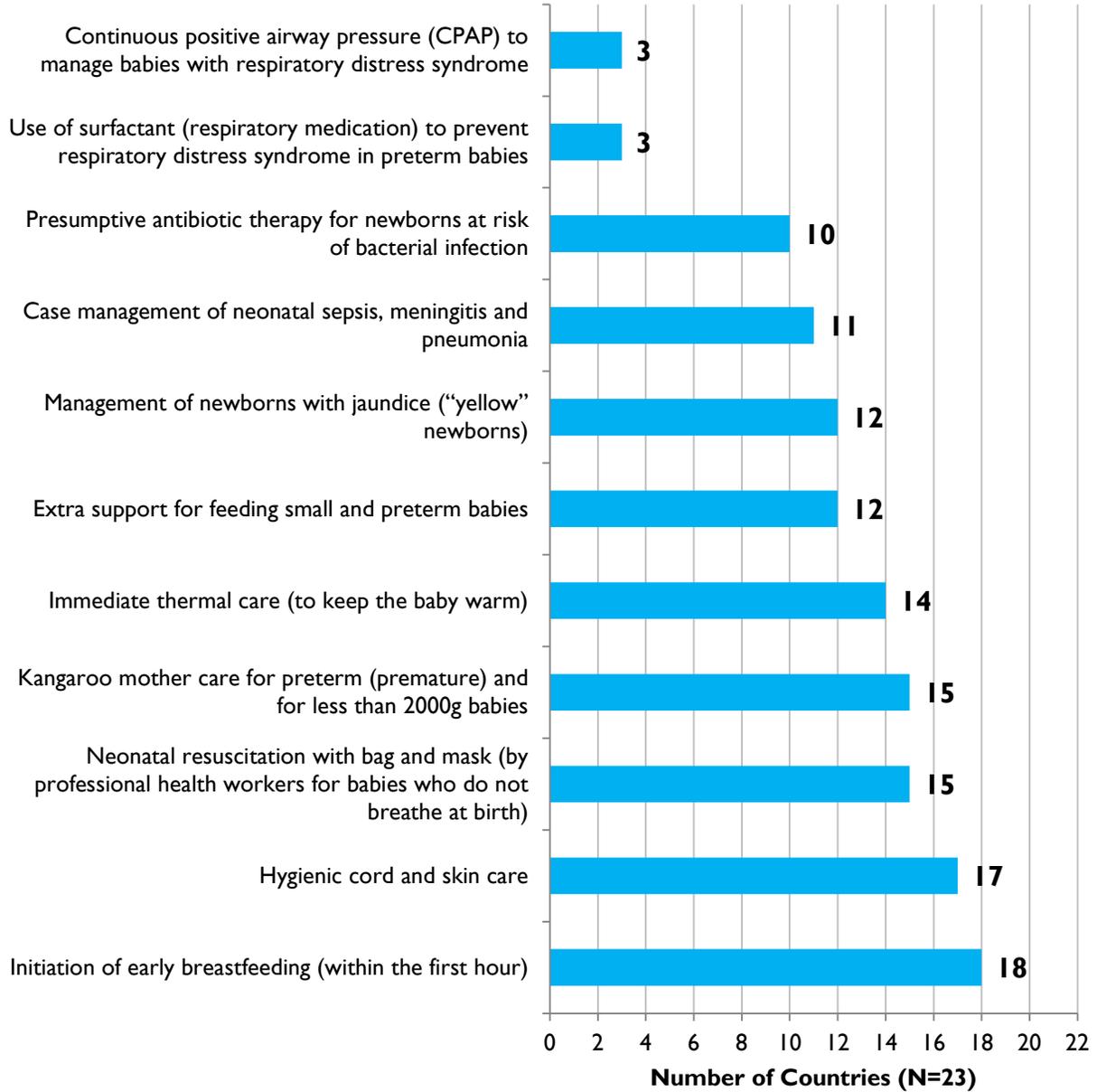
**FIGURE A1: INTERVENTIONS FOR FAMILY PLANNING INCLUDED IN EPHS**



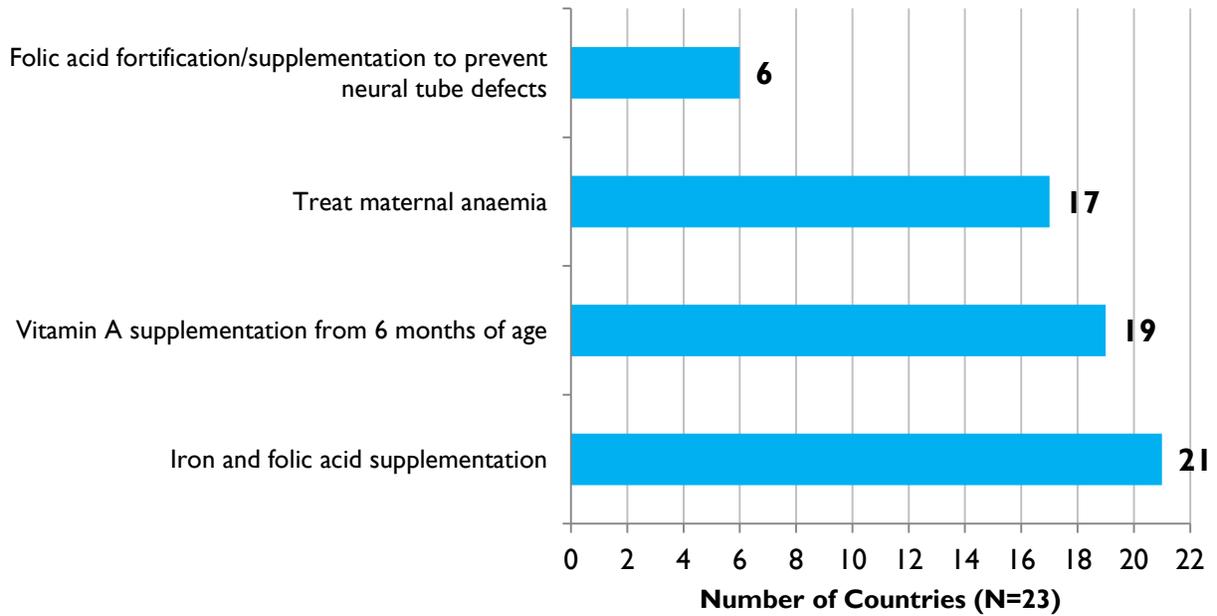
**FIGURE A2: INTERVENTIONS FOR CHILD HEALTH INCLUDED IN EPHS**



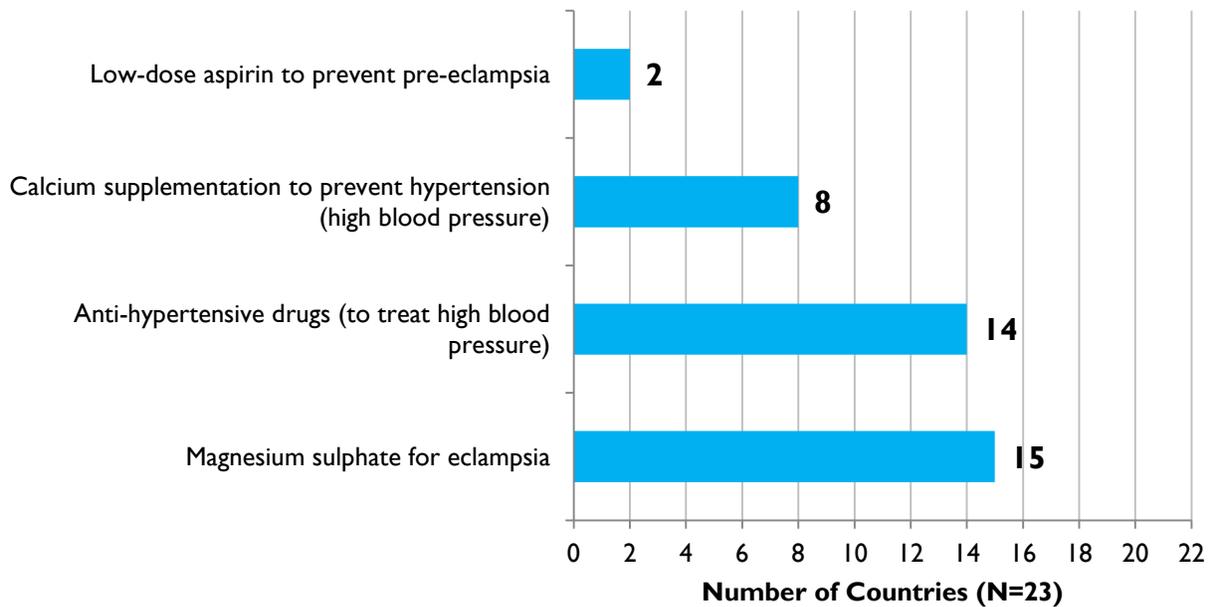
**FIGURE A3: INTERVENTIONS FOR NEWBORN HEALTH INCLUDED IN EPHS**



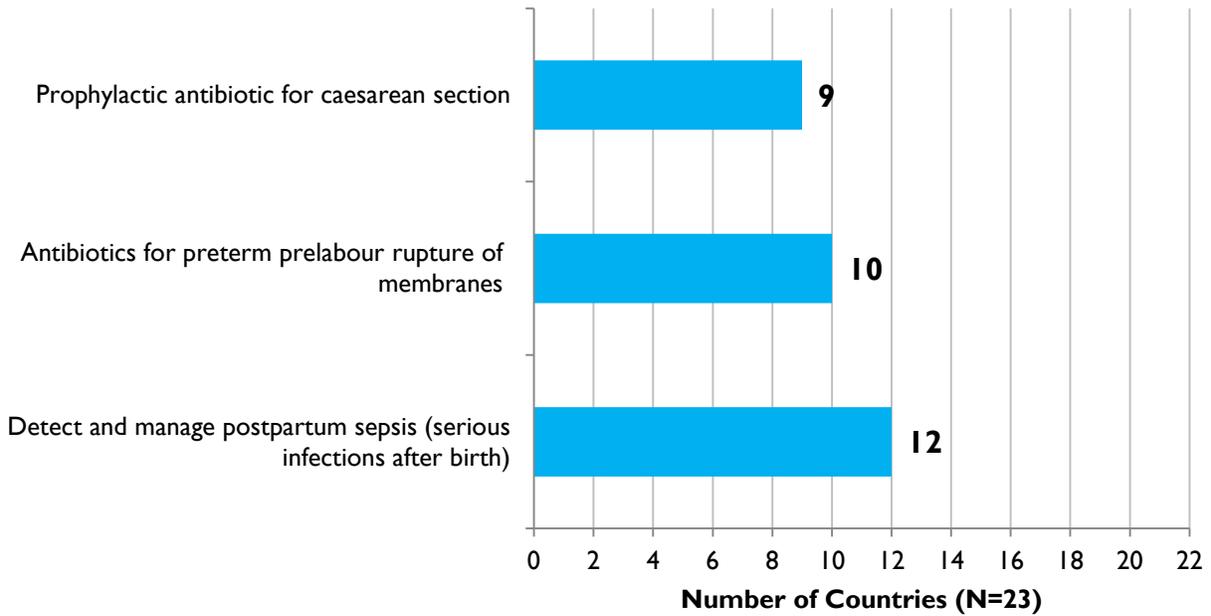
**FIGURE A4: INTERVENTIONS FOR PREVENTION OF MATERNAL AND CHILD ANAEMIA INCLUDED IN EPHS**



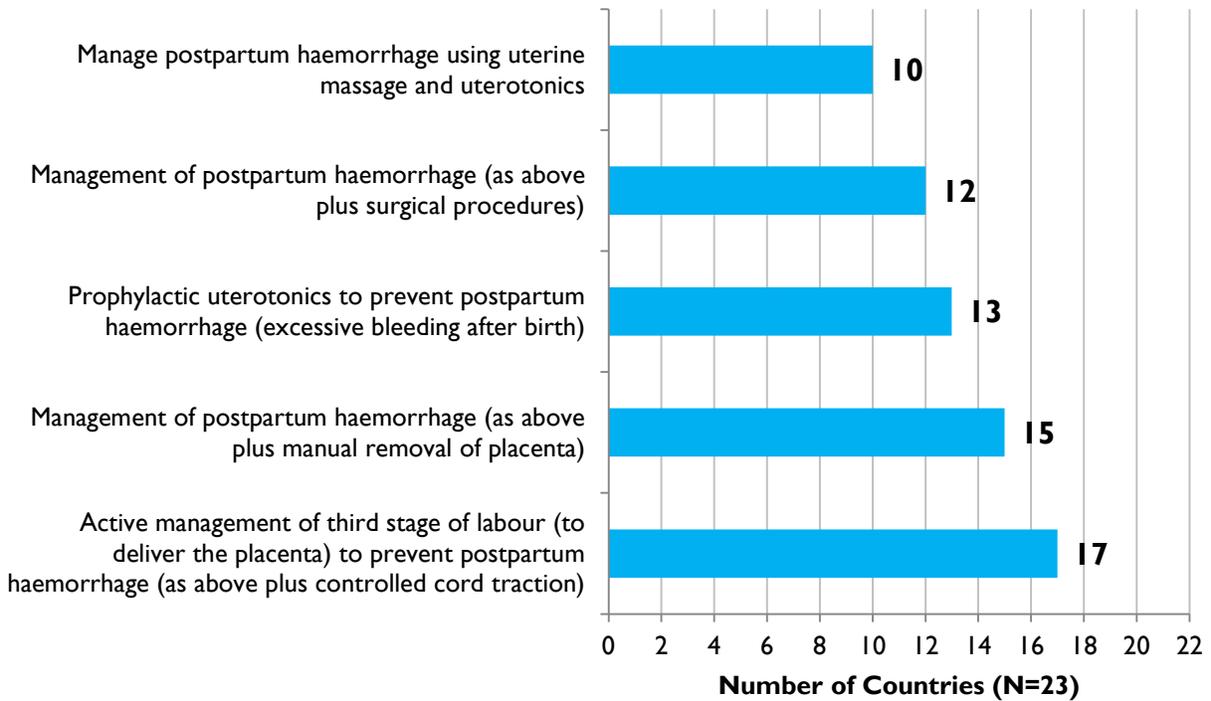
**FIGURE A5: INTERVENTIONS FOR PREVENTION OF ECLAMPSIA INCLUDED IN EPHS**



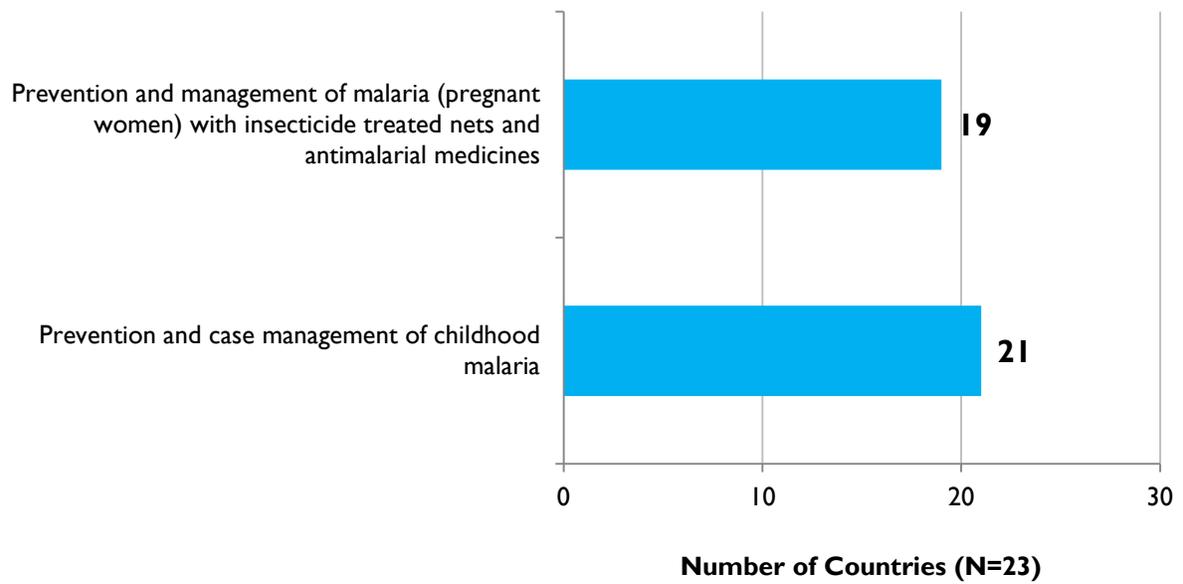
**FIGURE A6: INTERVENTIONS FOR PREVENTION OF MATERNAL INFECTIONS INCLUDED IN EPHS**



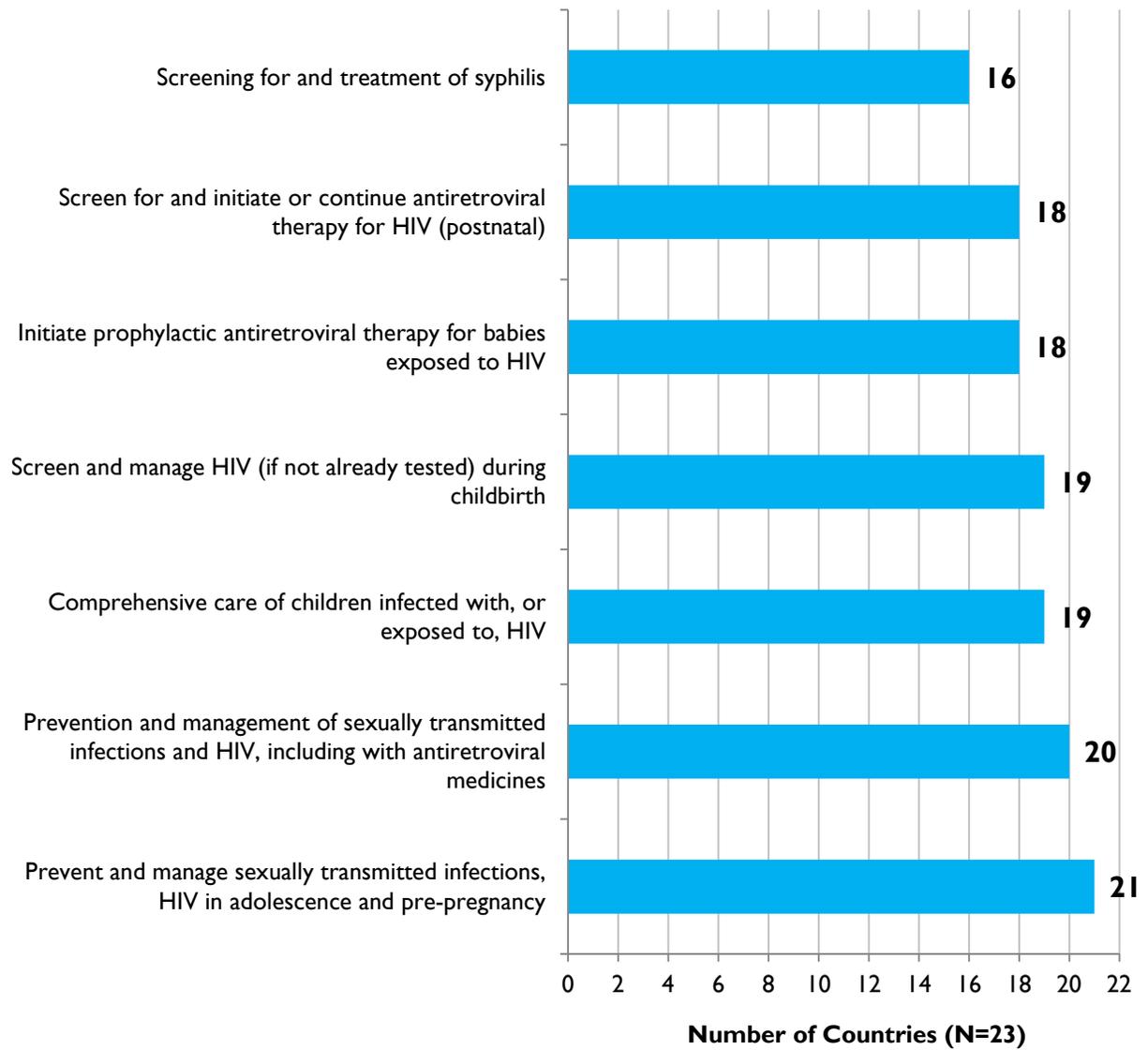
**FIGURE A7: INTERVENTIONS FOR PREVENTION AND MANAGEMENT OF POST PARTUM HAEMORRHAGE INCLUDED IN EPHS**



**FIGURE A8: INTERVENTIONS FOR PREVENTION AND MANAGEMENT OF MALARIA INCLUDED IN EPHS**



**FIGURE A9: INTERVENTIONS FOR PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS INCLUDED IN EPHS**











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