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Review

How effective has the essential health package been in improving priority setting in low income countries?

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ABSTRACT

The Essential Health Care Package (EHP) approach has been promoted as a tool for guiding priority setting (PS) in Low Income Countries (LICs). This approach was expected to improve PS by; *(i)* providing credible evidence, *(ii)* improving efficiency, *(iii)* making PS more transparent, explicit and objective, *(iv)* increasing public empowerment and accountability; and *(v)* improving equity. To date, there is paucity of literature discussing the degree to which the EHP approach has met these expectations. This review paper fills this gap. We demonstrate that the EHP approach has only marginally met some of the above expectations. While this has been blamed on the lack of resources and capacity to deliver the package, we argue that limited attention paid to the PS process and the context, failure to institute and strengthen the capacity of PS institutions, and lack of an inbuilt process of monitoring and evaluating the implementation of the approach, may have also contributed to the EHP's not meeting its expectations. While we use the example of the EHP approach, this discussion is relevant to any PS approach and the proposed recommendations (if implemented), would contribute to strengthening PS in LICs.

Introduction

Extreme resource constraints in low-income countries (LICs) present an enormous challenge to health policy-makers who are constantly faced with the decision of how best to allocate the limited resources (Doherty & Govender, 2006). This is further complicated by the lack of credible evidence and clear priority setting (PS) (or resource allocation) processes (Kapiriri, Norheim, & Heggenhougen, 2003). In response to this, the World Health Organization (WHO) and the World Bank recommended the Essential/Basic Health care Package (EHP) approach as a tool to guide PS, especially, in LICs. The EHP approach was expected to improve PS by: *(i)* providing credible evidence, *(ii)* improving efficiency, *(iii)* making PS more transparent, explicit and objective, *(iv)* increasing accountability and public empowerment; *(v)* improving equity (Musgrove, Chow, Shahid-& Salles, 2006). This review paper examines the extent to which the EHP approach actually met this expectation, and the related challenges.

The meager literature that has examined this issue reports that the EHP approach has not met its expectations, citing the lack of financial and human resources as the main barriers (Sengooba, 2004; WHO, 2008). We agree with this literature. However, we argue that addressing the additional limitations of the approach identified in this paper, would contribute to improving the effectiveness of this and any PS approach; even within contexts of extreme resource constraints. The challenges we identify are applicable to the EHP and other PS approaches and the recommendations would contribute to strengthening PS in LICs.

Background

The EHP is derived from assessing the cost-effectiveness of interventions against the leading causes of the disease burden. The most cost-effective interventions are selected to comprise the EHP. In order to maximize benefits from their investments, governments are then advised to focus their meager resources on delivering this package (Mulligan et al., 2006; Murray & Lopez, 2006). This approach was introduced in most LICs following the first global burden of disease and cost-effective analysis (BOD/CEA) study, where comprehensive and "universal" EHPs were defined for the different WHO regions (Jamison, 2006) (Supplementary Table 1). This was followed by national BOD/CEA studies (Gureje, Chisolm, Kola, & Lasebikan, 2007; McIntyre, Doherty, & Gilson, 2003) (Supplementary Table 2). Currently, the EHP appears in several LIC health policy documents, where they intend to prioritize the interventions comprising the EHP over other priorities (WHO, 2008).

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However, the EHP approach has been criticized in the literature. First, the approach assumes that maximizing health benefit is the main goal of the health care system (Paalman, Beckdam, Hawken, & Nyheim, 1998). This assumption is contentious. There is evidence that the public holds other values such as equity, which may, at times, conflict with efficiency (Jamison, 2006; Kapiriri et al., 2003). Second, by applying the same value choices overboard and failing to account for local and social-economic factors that influence disease epidemiology, there's an implicit assumption that societies and people's experiences of disabilities are similar (Anand & Hanson, 1997; Birn, Pillay, & Holtz, 2009). Third, it overlooks gender which is an important determinant of health (Allotey & Reidpath, 2002). Fourth, there is concern that PS based on this approach may re-emphasize vertical programs and global inequities by drawing attention away from conditions that typically affect the poor (Arnesen & Kapiriri, 2004; Birn et al., 2009; Doherty & Govender, 2006; Gwatkin, 2000). Lastly, the EHP approach, by focusing on technical methods and not the process, assumes that PS is technical. This runs contrary to the evidence that PS is a political process (Jamison, 2006; Kapiriri et al., 2003). Despite these criticisms, the EHP has continued to attract interest from national and international stakeholders, who have supported its use in several LICs (Birn et al., 2009; WHO, 2008; Xingzhu, 2003). There is paucity of literature discussing the degree to which the EHP approach has actually met its expectations. This paper fills this gap.

Methods

This is a short report based on literature review.

Sources

Our search included traditional data bases; Medline, PubMed and Cochrane; online reports; government policies; and web pages of international organizations such as; the WHO, the World Bank, and the Disease Control Priorities Project (DCPP); who supported the EHP initiative.

Search terms

The search terms used were developed to reflect the objective of the paper. To access the peer reviewed publications, we initially used general terms such as "essential health care/service package", "basic health care/service package ", "minimum health care/service package" and "health care/health service package". Since our focus was on LICs, we added the search words: "low-income countries", or "developing countries".

Selecting the articles

We limited our search to English language literature published between 1993 (year of the first BOD/CEA study) and 2011. We had just over 438 hits. We excluded papers with obviously irrelevant titles, news papers, editorials, magazines, and those based in high and middle- income countries. We downloaded and assessed the relevance of the remaining abstracts according to whether the article dealt with; the EHP or the BOD/CEA study, the use of the EHP in PS in LICs, experiences with using EHP in LICs. The initial screening reduced the number of relevant articles to 58, which were retrieved.

Assessment and analysis

The author and a research assistant read, assessed, and summarized the 58 articles under the subheadings of: *i)* date of publication; *ii)* setting of the study or report, *iii)* Definition of the mechanisms of EHP development, *iv)* stakeholders involved, *v)* uses of the EHP, *vi)* Implementation strategies/plans, *vii)* documented experiences. Only 33 articles provided the above information and were ultimately retained and included in the review (summarized in Table 1).

Our search for policy documents was limited to the most recent English language policy related documents/reports that mentioned the EHP approach and were published on the internet. A total of 23 policy documents were retrieved; 18 from Sub-Saharan African countries, four from Asia, and one from the Caribbean (Table 2 & Supplementary Table 3). These provided additional information about the development, contents, costs and constraints related to delivering the EHP.

Results

The results section is organized according to the expectations described in the introduction.

Providing evidence for priority setting

The EHP approach was expected to, and did provide credible evidence at the global level and within several LICs (e.g. in Uganda and Tanzania (the Tanzania Essential Health Package (TEHIP))), which has been used in discussions about PS (De Savigny, Kasale, Mbuya, & Graham, 2008; Doherty & Govender, 2006; Jamison, 2006; Kapiriri et al., 2003; Lopez, Mathers, Ezzati, & Jamison, 2006; Mulligan et al., 2006; Sengooba, 2004).

However, the credibility of the evidence used for LICs has been questioned (Allotey & Reidpath, 2002; Paalman et al., 1998). Furthermore, while the global BOD/CEA evidence has been updated (Jamison, 2006), most of the national evidence has not been updated due to limited technical and financial capacity to conduct the BOD/CEA studies in LICs (Kapiriri et al., 2003; WHO, 2008). In many cases, these studies were initiated and financed by development partners e.g. USAID in Djibouti; WHO, the World Bank in the East African region and in other countries (Birn et al., 2009; Bowie & Mwase, 2011; Ensor et al., 2002; Gureje et al., 2007; Nebie, 2008). Without this kind of support, several LICs have continued to use old evidence in spite of the changing epidemiological profiles and advancement in health technology (WHO, 2008).

Hence, while the EHP approach meets the expectation of providing credible evidence for PS at the global level; failure to update the information within LICs means that LICs are using outdated evidence or regional level evidence – which may not be reflect the current local situations (Doherty & Govender, 2006; WHO, 2008).

Table 1
List of reviewed national policies/strategic plans and years of publication.

Country	Year	Country	Year
Bangladesh	2007	Liberia	2007
Congo	2009	Malawi	2006
Djibouti	2008	Nepal	2006
Ethiopia	2005	Nigeria	2007
Gambia	2002	Senegal	2004
Ghana	2001	Sierra Leone	2010
Haiti	2004	Sri Lanka	2007
India	2008	Sudan	2006
Indonesia	2005	Tanzania	2002
Kenya	2005	Uganda	2010
		Zambia	2005