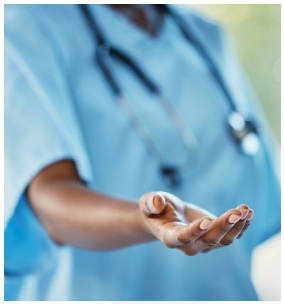

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Translating Evidence to Practice: Defining and Implementing Universal Health Coverage Health Benefits Packages across Contexts

Ala Alwan and Ole F. Norheim

ABSTRACT

This chapter explores how various countries have translated available evidence into priority setting and the processes they have followed in designing and implementing essential health service packages within the framework of universal health coverage. It draws on cross-cutting lessons from the experiences detailed in this volume and from an in-depth evaluation of the *Disease Control Priorities*, third edition (DCP3) Country Translation Project. The chapter highlights both successes and failures and discusses the necessary actions for transitioning from package design to effective implementation.

INTRODUCTION

More than 75 years ago, the constitution of the World Health Organization (WHO) defined health as a "state of complete physical, mental, and social well-being" (WHO 1946). The constitution envisaged the highest attainable standard of health as a fundamental human right of every human being. Since then, multiple declarations and resolutions have been endorsed by the United Nations to translate that right into concrete actions and ensure health for all. More recently, in September 2015, all United Nations Member States adopted the 2030 Sustainable Development Goals (SDGs) as an integrated global agenda to chart a new era for development and poverty reduction. One of the key targets in the health goal, SDG Target 3.8, requires all countries to achieve universal health coverage (UHC) by 2030 (UN General Assembly 2015).

UHC means that all people and communities have access to the full range of quality health services they need, when and where they need them, without financial hardship (WHO 2023). It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative health care. The ultimate responsibility of a country's health system lies with the government, and key aspects of this responsibility are to provide at least the minimum essential health services, reduce financial risk, and protect against catastrophic expenditures from out-of-pocket (OOP) health spending (WHO 2000). The type of essential health services covered and the pathway to UHC vary across countries, shaped by the health needs of their populations, health system capacity, and available resources.

Although all countries endorsed the UHC target in 2015, effective action has generally been slow and fragmented (WHO and World Bank 2023). As of 2023, the global UHC service coverage index was 68 out of 100, with about 13.5 percent of households facing catastrophic health expenditure—that is, OOP expenditure greater than 10 percent of household budget (consumption or income). At current rates of progress for both service coverage and financial hardship, as of 2023, only an estimated 270 million of the 1 billion people targeted to benefit from UHC by WHO's Thirteenth General Programme of Work 2019–2023 (WHO 2019) were covered by essential health services without risk of catastrophic OOP health spending—a shortfall of about 730 million people.

Translating declared commitments into effective action requires political leadership at the highest level. In September 2019, four years after the endorsement of the SDGs and the UHC target, heads of state and government convened a high-level meeting at the United Nations General Assembly and committed to scaling up efforts to achieve SDG Target 3.8, adopting the most effective, evidence-based, high-impact, and quality-assured interventions and using public spending as the main driver (UN General Assembly 2019). Four years later, in September 2023, a second high-level meeting was convened to reinvigorate global action on UHC. However, the resulting political declaration does not appear to contain a different approach to achieve a breakthrough (UN 2023).

Strengthening health systems through strong primary health care is essential for attaining the UHC target. Countries need to redouble their efforts in improving access to, and delivery of, evidence-informed essential health services. Defining and implementing an affordable package of essential health services are at the center of health reforms leading to UHC. In this respect, most countries will need to reinforce their technical capacity in the areas of setting priorities and designing, financing, implementing, and monitoring UHC packages and related health service delivery reforms.

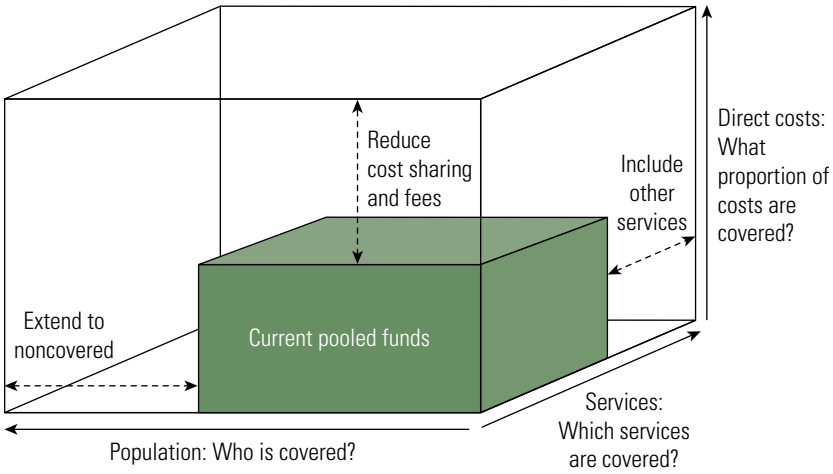
This volume presents country experience in translating available evidence into priority setting and defining and implementing essential packages of health services (EPHSs) or health benefits packages[1] in the context of UHC (part 1). The volume also extracts cross-cutting lessons learned from those country

experiences and seeks to identify both successes and failures (part 2). Although the review of experiences covered in this volume focuses primarily on the countries involved in the country translation initiative set out in the previous edition, the volume includes other countries as case studies in priority setting: Colombia, India, the Islamic Republic of Iran, Malawi, Mexico, and Nigeria. The key challenges, lessons learned, and conclusions presented in this chapter are highly relevant to the situation in most low- and lower-middle-income countries.

DISEASE CONTROL PRIORITIES AND UHC

UHC consists of three fundamental dimensions: (1) expanding coverage to the whole population, (2) reducing financial risk, and (3) extending the range of essential services. Initiatives to accelerate progress on UHC need to address all three dimensions (figure 1.1).

Figure 1.1 The Three UHC Dimensions



Source: Boerma et al. 2014.

Note: UHC = universal health coverage.

To scale up UHC, countries need to define priority services and incrementally expand the range of services offered to noncovered populations; at the same time, they need to reduce cost sharing and financial risk through resource mobilization, revenue generation, resource pooling, and strategic purchasing. Defining priority services will not work without action to improve access and clear links to health financing mechanisms. One strategic framework used by an increasing number of countries to identify the services to be prioritized for public subsidy consists of the evidence provided and the approach adopted by the third edition of *Disease Control Priorities* (*DCP3*) and its model service packages (Jamison, Gelband, et al. 2018; Watkins et al. 2018). *DCP3* provides a systematic review of the evidence, including cost-effectiveness, of a wide range of health services to support policy makers in decision-making on the highest-impact investments in the context of limited resources.

Based on the *DCP3* evidence, two generic model UHC packages of essential health services were launched in December 2017 as a starting point for evidence-informed country-specific analysis of priorities that countries can consider in designing their packages and charting the road map to UHC (Jamison, Alwan, et al. 2018). Health services were selected for inclusion in the model packages using the following criteria: evidence of impact, cost-effectiveness, financial risk protection, equity, and feasibility of implementation (Jamison, Gelband, et al. 2018). The essential UHC package includes 218 health sector interventions for lower-middle-income countries, with a subset of interventions distilled into a highest-priority package of 108 interventions recommended for low-income countries. In addition to its focus on investing in high-priority interventions, DCP3 also addresses the three UHC dimensions. A properly designed package of essential health interventions, funded publicly or through mandatory prepayment schemes, can reach all people, improve access to these services, and reduce financial risk.

For low- and lower-middle-income countries, the *DCP3* approach recommends implementing the package in a stepwise manner through a progressive universalism approach (Jamison et al. 2013). In that way, those countries can design the package to initially provide highly cost-effective health services, particularly for diseases that disproportionately affect the disadvantaged. As health resources and health system readiness grow, countries can expand the package to include a wider range of interventions and a higher level of coverage.

The *DCP3* and other model packages cannot be uniformly applied to any given context. They should be contextualized by countries' disease burden, health care needs, health system capacity, health policy objectives, and available financial resources. Many countries have recently used the *DCP3* evidence and approach to develop and implement their own EPHS (Alwan, Jallah, et al. 2023; Alwan, Siddiqi, et al. 2023; Alwan, Yamey, and Soucat 2023; Blanchet et al. 2020; Eregata et al. 2020; NHSRC, WHO, and the DCP3 Secretariat 2019; Somalia, Ministry of Health and Human Services 2021). Some of those countries have received technical support from the DCP3 Country Translation Project.[2] The project also reviewed the experience of six of those countries—Afghanistan, Ethiopia, Pakistan, Somalia, Sudan, and Zanzibar—in priority setting and designing their own packages to identify strengths and challenges and to update technical guidance for other countries (Alwan, Yamey, and Soucat 2023). Liberia was subsequently added to this group of countries (Alwan, Jallah, et al. 2023).

The review process involved a knowledge network of experts, seven groups of professionals addressing specific areas of EPHS development, and three review meetings organized in Geneva and London. The outcome of the review, which includes lessons learned, resulted in the publication of an editorial and seven papers in January–May 2023 (Alwan, Majdzadeh, et al. 2023; Alwan, Yamey, and Soucat 2023; Baltussen, Mwalim, et al. 2023; Danforth et al. 2023; Reynolds et al. 2023; Siddiqi et al. 2023; Soucat, Tandon, and Gonzales Pier 2023). Another series of papers covering the experience in Pakistan was subsequently published in 2023 and

2024 (Alwan et al. 2024; Alwan, Siddiqi, et al. 2023; Baltussen, Jansen, et al. 2023; Huda et al. 2023; Raza et al. 2024; Torres-Rueda et al. 2024). Some of those papers, which guided the writing of this chapter, have been revised and reprinted as chapters 2–6, 14–15, and 17–19 in this volume.

COUNTRY AND ECONOMY EXPERIENCES

The six countries and one economy participating in the review are classified by the World Bank as either lower-middle-income (Pakistan and Zanzibar, a semiautonomous region of Tanzania) or low-income (the remaining five). This section provides a brief outline of the findings and conclusions of the review. Several published articles present a more elaborate account of the different aspects of the package design process (Alwan et al. 2024; Alwan, Jallah, et al. 2023; Alwan, Yamey, and Soucat 2023), as do the official websites of the relevant ministries of health and several chapters in this volume.

General information on the health and health financing indicators in the six countries and one economy appears in table 1.1, which was adapted and updated from an earlier publication (Alwan, Majdzadeh, et al. 2023). The six countries and one economy have a low service coverage index, ranging from 27 to 45, and health care financing environments characterized by limited funding and major resource gaps and challenges. They have low per capita current health expenditure, ranging from US$23.4 to US$80.3, and government per capita spending as low as US$6.00. Apart from Zanzibar, the countries have very high OOP expenditure, reaching 75 percent of total health expenditure in Afghanistan. All have defined their own packages as a key milestone for the realization of UHC.

Table 1.1 Selected Health System Indicators in the Six Focus Countries and One Economy

	Afghanistan	Ethiopia	Liberia	Pakistan	Somalia	Sudan	Zanzibar
UHC Service Coverage Index (2021)	41	35	45	45[b]	27	44	43
Incidence of catastrophic health expenditure as % of households paying >10% (year)[a]	23.8 (2016)	2.1 (2015)	6.7 (2016)	5.4 (2015)	—	18.4 (2009)	4.3 (2018)
Current health expenditure per capita, US$ (2020)	80.3	28.7	56.7	38.2	—	23.4	39.3
Domestic general government health expenditure as % of gross domestic product (2020)	1.2	0.98	1.6	1.0	—	1.0	1.6
Government spending for health per capita, US$ (2020)	6.1	8.1	9.5	13.4	—	8.0	16.8
Domestic general government health expenditure as % of general government expenditure (2020)	4.2	6.8	4.5	5.12	2.0	9.6	9.4
Out-of-pocket expenditure as % of current health expenditure (2020)	74.8	33.0	46.9	55.4	—	53.0	23.1

Sources: Based on data from the World Health Organization's Global Health Observatory, https://www.who.int/data/gho/data/indicators (accessed July 19, 2024), and Global Health Expenditure Database, https://apps.who.int/nha/database (accessed July 19, 2024).

Note: UHC = universal health coverage; — = not available.

a. Data from WHO and World Bank 2021.

b. WHO Global Health Observatory data, which differ from the UHC Service Coverage Index of 49.9 reported in 2020 by Pakistan's Ministry of National Health Services Regulations and Coordination.

Table 1.2 provides an overview of the characteristics of the EPHS in each of the seven focus countries and economy. Five already had a package, and the current EPHS in those countries and economy represents a revised and expanded version. Only two countries, Ethiopia and Sudan, developed their packages for the first time. All used *DCP3* evidence to guide the prioritization of essential health services, but two countries, Ethiopia and Sudan, used additional sources of evidence, such as WHO's UHC Compendium.[3] The time required to design the packages, including evidence-informed prioritization and costing, ranged from eight months to three years. Prioritization covered five health service delivery platforms (community, health center, first-level hospital, tertiary care, and population-based interventions), but two countries, Liberia and Pakistan, decided to focus initially on a primary care package designed according to the structures of their own health systems. Liberia's core package covers community, clinic, health center, and first-level hospital platforms; Pakistan's final package covers community, health center, and first-level hospital platforms.

As mentioned earlier, all six countries and one economy faced a major challenge of limited fiscal space for public expenditure on health. They adopted different approaches to address that challenge, with decisions on package financing varying across them. Depending on their national vision, those endorsing a primary health care package (Liberia and Pakistan) decided to publicly finance the core or high-priority services, whereas the remaining four countries and one economy adopted financing mechanisms that included other prepayment schemes, including health insurance schemes, combined with user fees and donor funding.

Table 1.2 Main Characteristics of the EPHS in the Six Focus Countries and One Economy

	Afghanistan	Ethiopia	Liberia	Pakistan	Somalia	Sudan	Zanzibar
Year package completed	2021	2019	2022	2020 (generic EPHS), 2021 (6 provincial EPHSs)	2020	2022	2022
Time to construct the package	2 years	1–2 years	8 months	2 years	1–2 years	2 years	3 years
Main source of evidence adopted	*DCP3*	*DCP3* expanded with the UHC Compendium	*DCP3*	*DCP3*	*DCP3* and UHC Compendium	*DCP3*	*DCP3*
New package or revision of a previous package	Revision and expansion	Revision and expansion	Revision and updating	New package[a]	Revision and expansion	New package	Revision and updating
Delivery platforms targeted by the package	All delivery platforms[b]	All delivery platforms	Primary health care platforms[c]	District-level platforms[d]	All delivery platforms	All delivery platforms	All delivery platforms
First year cost of the core package in US$/person[e]	6.90	40.0	14.18; 6.93 cost to the government[f]	13.00 for the federal EPHS[g]	8.00	23.30	37.00

table continues next page

Table 1.2 Main Characteristics of the EPHS in the Six Focus Countries and One Economy (continued)

	Afghanistan	Ethiopia	Liberia	Pakistan	Somalia	Sudan	Zanzibar
Number of interventions in the final package	158	1,018	128 (78 core; 50 complementary)	88	412	824	314
Position of the country on the source of financing the final package	Prepayment schemes and donor funding	Public finance, donor funding, and user fees	Public finance and donor funding for core subpackage[h]	Public finance with gap filling from donor funding	Public finance, donor funding, and user fees	Public finance, prepayment, donor funding, and user fees	Public finance, public health insurance, prepayment, donor funding, and user fees

Source: Adapted from Alwan, Majdzadeh, et al. 2023.

Note: DCP3 = Disease Control Priorities, third edition; EPHS = essential package of health services; UHC = universal health coverage.

a. A rudimentary EPHS existed in two provinces focusing on a few programs.

b. DCP3 delivery platforms are community, health center, first-level hospital, referral and specialty hospitals, and population-based interventions.

c. Liberia's UHC package consists of a core subpackage, which includes interventions at the primary health care level, and a complementary subpackage, which includes health center and district, county, and tertiary hospital interventions.

d. The government prioritized and costed all five delivery platforms but decided to initially implement the three district-level platforms.

e. All packages will have increasing coverage along the timeline of Sustainable Development Goal Target 3.8; the projected costs will be considerably higher and require an increase in health allocation.

f. The total cost of the complementary package is US$13.82, with a cost to the government of US$5.35. The total cost of the core and complementary subpackages is US$28.00, with a total cost to the government of US$12.28.

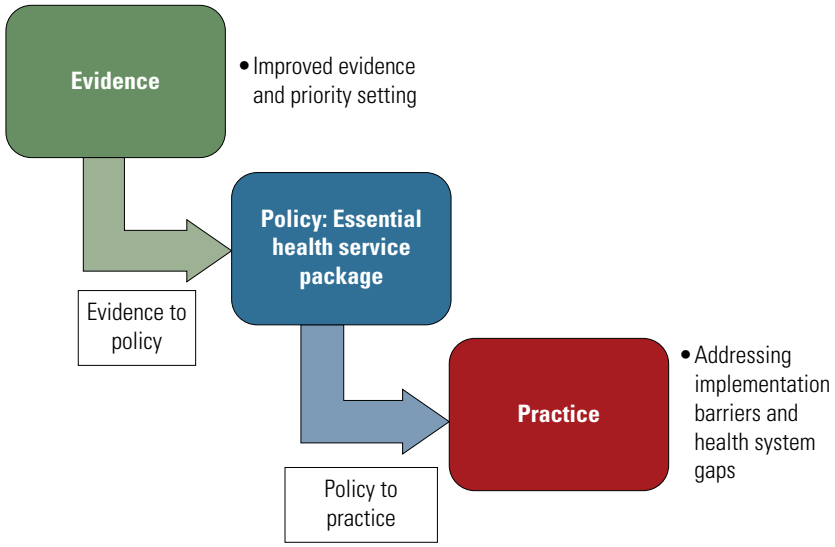
g. The EPHS in each province/area has a different set of interventions and a different unit cost.

h. The complementary subpackage will be financed through the Liberian Ministry of Health's cost-sharing program.

As partly evident in tables 1.1 and 1.2, the review of the country and economy experience highlights critical challenges at different stages of EPHS development. Some of those challenges relate directly to the processes and methodologies used, including gaps in preparedness and readiness; other challenges are inherent in the capacity, resources, and performance of the health system. The challenges were compounded by the timing of the package design process in some of the countries and the economy, which coincided with the height of the COVID-19 (coronavirus) pandemic.

National efforts in prioritizing essential services to achieve UHC succeed only when the selected services become accessible to all population groups. Many countries designing EPHSs face major challenges in transitioning from design to implementation. Those challenges often stem from limited financing and health system gaps resulting from a disconnect between benefit package design (including the processes, methodologies, feasibility, and affordability) and health system reforms, which policy makers often struggle to address. Therefore, the assessment of country experiences in this chapter distinguishes clearly between two phases of successful priority setting: (1) evidence to policy and (2) policy to practice (refer to figure 1.2).

Figure 1.2 Two Phases of Designing and Implementing Essential Packages of Health Services



Source: Original figure created for this publication.

The next sections of the chapter focus on the lessons learned, with special emphasis on key messages for policy makers regarding (1) the phase of evidence to policy (that is, defining or revising an implementable EPHS) and (2) the phase of policy to practice (that is, actually implementing the EPHS). At a general level, although many of the country case studies document substantial improvements compared to earlier efforts in terms of evidence synthesis and the processes adopted to move from evidence to policy, most countries experience a large implementation gap in moving from policy to practice.

FROM EVIDENCE TO POLICY AND SUBSEQUENT ACTION

Investing in designing an evidence-informed EPHS has little value if the process does not lead to high-level government endorsement and subsequent action (Alwan, Majdzadeh, et al. 2023). Achieving a successful outcome requires meeting specific prerequisites, principles, and standards. The country translation review examined existing experience in the appropriate design of UHC packages and recommended a framework outlining the essential requirements for the transition from package design to implementation and improved access to services (Alwan, Majdzadeh, et al. 2023). Box 1.1 summarizes the key components of the framework.

Box 1.1

A Framework for Action on Country and Economy Readiness and Prerequisites for the Successful Design and Implementation of a UHC EPHS

Evidence to policy

Defining and agreeing on the objectives of an essential package of health services (EPHS) design and securing political commitment

- Reaching consensus on the justification and objectives of designing an evidence-informed EPHS
- Securing sustained commitment and a clear government position on universal health coverage (UHC) in the national health vision and strategic plans, including serious engagement of the finance and planning sectors
- Securing commitment at the level of parliament
- Securing commitment at the subnational level, particularly in decentralized/federal systems.

Engaging key stakeholders

- Conducting stakeholder analysis of key national players
- Ensuring early, meaningful, open, and inclusive engagement of key stakeholders
- Building national consensus and conducting public dialogue on health service priority setting
- Mobilizing multilateral agencies and key development partners (where relevant).

Assessing health system readiness and performance and financing mechanisms

- Conducting an in-depth assessment of the health system, including governance structure, delivery arrangements, health workforce, and supplies, including medicines
- Assessing the fiscal space, health financing mechanisms, sustainability of health financing, and the level of public funds provided to finance the package
- Mapping the health services currently provided against prioritized health services covered by UHC model packages.

Developing and implementing a road map for the EPHS design process

- Developing a road map that comprehensively describes the entire design process
- Agreeing on principles of the design process: national ownership, transparency, data-driven decision-making, and focus on feasibility and affordability
- Building the capacity of the technical core team and key stakeholders
- Setting a governance structure for dialogue and deliberation
- Agreeing on decision criteria for prioritization of health services
- Defining the scope of the EPHS, including health delivery platforms targeted
- Prioritizing and costing interventions based on agreed decision criteria and linking costing to budgeting and financing mechanisms.

box continues next page

Box 1.1 A Framework for Action on Country and Economy Readiness and Prerequisites for the Successful Design and Implementation of a UHC EPHS (continued)

Policy to practice

Securing a successful transition to sustainable implementation

- Developing an implementation plan that addresses health system constraints
- Ensuring affordable and sustainable financing of the EPHS
- Aligning the packaging of EPHS with the service delivery
- Establishing a monitoring framework and revising the package accordingly
- Institutionalizing technical capacity and skills within the Ministry of Health and ensuring regular EPHS revision
- Addressing the risks of instability in fragile and politically unstable contexts, and instituting risk-mitigation measures with stakeholders.

Source: Adapted from Alwan, Majdzadeh, et al. 2023.

FROM EVIDENCE TO POLICY: PREREQUISITES FOR THE SUCCESSFUL DESIGN OF THE EPHS

This section of the chapter provides a brief outline of the key elements of the framework with special emphasis on the first phase—evidence to policy.

Defining the Objectives of EPHS Design

A key factor affecting the success of EPHS design is establishing a good understanding of why the EPHS is required and its intended goals. Such clarity beforehand could help streamline the approach, improve communication, and clarify stakeholder expectations, thus increasing the likelihood of creating a feasible package. The objectives may vary depending on whether the EPHS is being developed for the first time or is a revision. If the budget space has limited room for growth, the design could prioritize enhancing the transparency, explicitness, affordability, efficiency, and fairness of the current package. If an increase in fiscal space for health is projected, additional focus could be placed on expanding the EPHS by including underfunded interventions.

Securing Sustained Political Commitment and Leadership

Political commitment to UHC and the resolve to improve access to essential health services are key prerequisites for the successful design and implementation of UHC packages. Such commitment should be translated into full endorsement of the UHC target by the government in its national health vision and strategies and should come with adequate financing. Early and serious engagement of government planning and finance sectors is an essential part of this commitment to address the fiscal space for health. The critical challenges of health system strengthening and adequate financing often require the political backing of the parliament, ministerial

cabinet, and subnational governments (in the case of a decentralized system). Only two countries reported some engagement of parliamentarians at certain stages of the package development process, but even those parliamentarians made no formal decisions or resolutions on UHC or the EPHS. Priority setting and package design are major undertakings that require considerable technical resources and capacity strengthening. Making such an investment in the absence of sustained high-level government decisions is unlikely to result in a significant impact.

Although all countries reviewed in this volume illustrated an initial political commitment to develop and implement the EPHS, the sustainability of that commitment in implementing the EPHS represents a major challenge, particularly in countries facing political instability. Afghanistan, Ethiopia, Pakistan, Somalia, and Sudan consistently have high global rankings in terms of their vulnerability to political instability or politically motivated violence. Since defining their packages, Afghanistan underwent a regime change; Pakistan, Somalia, and Sudan experienced shifts in government; and Ethiopia and Sudan have been in civil war. Such instability is commonly associated with economic constraints and a restricted budget for health and social services.

Engaging Key Stakeholders

As mentioned earlier, national ownership of the process and its outcome requires engaging key internal and external stakeholders throughout the design process. Thus, conducting a comprehensive stakeholder analysis and developing key engagement plans are essential; however, the types of stakeholders, modalities, and depth of engagement vary by country. Table 1.3 provides a list of the main stakeholders involved in the *DCP3* country translation review.

Table 1.3 Stakeholder Involvement in the EPHS Process in the Six Focus Countries and One Economy

	Number of countries (Total = 7)
Countries and economy conducting stakeholder analysis	2
Countries and economy engaging key national stakeholders	
Parliament	2
Finance	2
Planning	4
Community and patients groups	1
Private sector	2
National academia	4
Countries and economy engaging multilateral organizations and development partners[a]	
World Health Organization	7
United Nations Children's Fund	5
United Nations Population Fund	3

table continues next page

Table 1.3 Stakeholder Involvement in the EPHS Process in the Six Focus Countries and One Economy (continued)

	Number of countries (Total = 7)
United Nations Development Programme	0
Bill & Melinda Gates Foundation	4
US Agency for International Development	4
World Bank	4
Engagement of international academic institutions or consultancy firms	6

Source: Adapted from Alwan, Majdzadeh, et al. 2023.

a. Additional partners for Ethiopia included the World Food Programme, United Nations (UN) International Organization for Migration, UN health and nutrition cluster, and the countries of Canada, Finland, Germany, Italy, Norway, Sweden, Switzerland, and the United Kingdom. For Liberia, they included the German Agency for International Cooperation and Last Mile Health through the Technical Working Groups. For Pakistan, they included the Global Fund; GAVI, the Vaccine Alliance; and the UK Foreign, Commonwealth and Development Office. For Somalia, they included the European Union. For Sudan, they included the European Union, GAVI, the Global Fund, and the countries of Canada, Germany, Italy, Sweden, Switzerland, and the United Kingdom.

Although all stakeholders engaged in the countries covered by the DCP3 review are important, civil society dialogue and engagement among community groups play a critical role, particularly in understanding and considering priority health needs. Only one country has partly acknowledged this requirement, and no country has engaged in serious interaction with people's representatives.

Assessing Health System Readiness and Financing Mechanisms

A key prerequisite for developing a properly designed and feasibly implemented UHC package is to conduct reliable assessments of the health system and financing mechanisms. The assessments should aim to identify gaps that impede access to essential services across the different building blocks of the health system. All the countries reviewed have considerable weaknesses in their health systems, but the experiences documented in this volume indicate that most countries did not conduct a comprehensive review. When countries did conduct such a review, the assessment tended to underestimate or even ignore the gaps, thus undermining the transition from package design to implementation.

Experience shows that mapping the availability and coverage levels of services already provided by the public health sector constitutes another important part of the assessment. It provides the necessary information on baseline offerings in terms of health services and on missing essential interventions that the prioritization phase should include. The Technical Working Groups—made up of experienced health professionals in health systems, reproductive and maternal and child health, communicable diseases, and noncommunicable diseases—play a central role in

this task, particularly in analyzing existing services against the contents of model packages like the DCP3 essential UHC, the DCP3 highest-priority package, and the menu of health services in the WHO UHC Compendium. This step will help determine the total number of interventions (existing and proposed) that will be submitted for the evidence-based prioritization process (Alwan, Jallah, et al. 2023; Alwan, Siddiqi, et al. 2023).

Another essential component of health system assessments is a detailed analysis of existing financing mechanisms and fiscal space for health to guide the EPHS design process and to ensure the affordability of the recommended package along the SDG timeline. Adequate funding should not only cover initial implementation but should also account for population growth in some countries; the progressive increase in the coverage of interventions along the UHC timeline will result in rising costs that will far exceed the current expenditure for health and any forecasted economic growth. Ideally, part of the fiscal space assessment should involve exploring the potential for increasing health allocations based on projections for economic growth and government funding and on objective forecasts of partner and donor funding.

Developing and Implementing a Road Map for EPHS Design

Several of the review countries and economy developed an operational plan and road map at the outset. Those road maps cover the EPHS's scope, objectives, process, and required actions, and a timeline for the different steps in EPHS development. In their road maps, countries have included the establishment of a special unit within the Ministry of Health and a comprehensive governance structure covering roles and responsibilities of the key actors and stakeholders. The governance structure included the formation of Technical Working Groups to lead the work in prioritizing essential health interventions. The following subsections briefly discuss the critical components of the road map.

Prioritization of Essential Health Services A starting point for the prioritization process involves reaching consensus on the decision-making criteria the country will adopt to select interventions or services. This undertaking presents challenges because stakeholders need to agree on the principles and criteria and because the selection of criteria must be evidence-informed and participatory. Benchmarking global experience, reviewing the sector's existing values and principles in health policies and strategies, and conducting transparent deliberations could help in identifying the criteria and reaching consensus. Countries considered the following key criteria: (1) burden of disease, (2) effectiveness, (3) cost-effectiveness, (4) financial risk protection, (5) quality of evidence, (6) equity and targeting vulnerable populations. (7) feasibility of implementation, and (8) budget impact. Several publications, as well as other chapters in this volume, cover the definitions and additional information on the decision criteria adopted by some countries (refer to Alwan, Jallah, et al. 2023; Alwan, Siddiqi, et al. 2023; Baltussen, Mwalim, et al. 2023).

Evidence Synthesis and Analytics The identification and ranking of candidate health interventions for priority setting require the gathering and synthesizing of various data and evidence. Experience shows that collecting and collating evidence on the decision-making criteria are challenging and time-consuming given the frequently weak health information systems, inadequate capacity, and scarcity of locally generated accurate data in many countries. Decision-makers should make every effort to use the most locally relevant evidence. When countries did not have available local evidence, often the case for cost-effectiveness evidence, they consulted regional and international data sources and recommendations. All the reviewed countries and economy in this chapter used multiple sources, such as the Institute for Health Metrics' Global Burden of Disease, DCP3, the WHO UHC Compendium, and the Tufts Cost-Effectiveness Analysis Registry, as well as local expert opinion when data were not available.

Getting data on the equity and financial risk protection impacts of interventions also presented challenges. Even with available data, however, trade-offs among multiple criteria can make priority-setting decisions difficult. To overcome such challenges, countries apply deliberative decision-making, highlighting the importance of decision-facilitating analytics tools. Some tools commonly used in EPHS design include the FairChoices DCP Analytics Tool, the Health Interventions Prioritization Tool, the OneHealth Tool, and the UHC Service Package Delivery and Implementation Tool.

Costing and Fiscal Space All health interventions set for prioritization will require economic evaluation and costing to assess their budget impact. Costing interventions and estimating the budget impact of the whole EPHS are challenging, and results may be indicative rather than accurate. Gaudin et al. (2023) conducted a survey to review the EPHS costing experience in five countries as part of the DCP3 country translation review (refer to chapter 16 in this volume). The review shows a wide variation in the application of costing methodologies and interpretation of terminology, particularly regarding common health system–related costs and capacity constraints in low- and lower-middle-income countries. That variation calls for more systematic guidance and standard ways to implement economic evaluation methods.

The results and conclusions of the survey suggest that the usefulness of costing depends entirely on the availability and accuracy of costing data (chapter 16). Reporting ranges of uncertainty, conducting sensitivity analysis, and ensuring transparency in the methods and assumptions used could improve trust, policy relevance, and the use of costing estimates in decision-making. The study strongly recommends routine gathering of costing data and training to properly collect and use those data. It also notes the critical importance of ensuring that the package is properly designed and integrated into a country's budget cycle. The survey found that none of the DCP3 review countries had explicitly linked costing with

the budgeting process, which is essential for implementation. Finally, the study recommends engaging in long-term capacity building in costing as an integral part of institutionalizing the EPHS design process.

Prioritization of costed health interventions is based on the agreed decision criteria, with serious consideration of the funding envelope agreed to finance the EPHS. When the cost of the recommended high-priority interventions exceeds the available fiscal space for public expenditure, countries may need a subsequent round of prioritization to develop another version of the EPHS that aligns with the government resource envelope. For instance, both Liberia and Pakistan needed a second phase of prioritization. In Liberia, the government decided to split the initially recommended package into two subpackages, proposing a core, publicly financed package of high-priority primary health care interventions and a second package to be implemented through a cost-sharing program (Alwan, Jallah, et al. 2023). In Pakistan, the outcome of the second phase was an implementation package endorsed for immediate rollout. Pakistan approved the full national EPHS with a larger number of interventions for implementation if and when the country could increase health allocations (Alwan, Siddiqi, et al. 2023). In both countries, the final EPHS was endorsed at the highest level of the health sector.

Overall Assessment

Despite several shortcomings, many of the country and economy case studies reported in this chapter show the possibility and feasibility of building on existing evidence to develop a policy-relevant EPHS. The case studies show the substantial efforts made to synthesize evidence on the costs and effectiveness of health interventions. National capacity exists (even if it is scarce) to conduct all or part of the technical work, sometimes with support from international partners (WHO, World Bank, development agencies, academic institutions, and—perhaps too often—consultants). Countries often have road maps and governance structures in place, and the processes of translating evidence into policy have improved, with broader stakeholder involvement, even if none of the processes can be said to be fully open and inclusive. Few of these efforts, however, have translated from policy to practice, as discussed in the next section. Several of the chapters in part 2 of this volume also discuss these efforts.

FROM POLICY TO PRACTICE: SECURING A SUCCESSFUL TRANSITION TO SUSTAINABLE IMPLEMENTATION

Many countries had developed EPHSs before the SDG era, but not all successfully implemented them (Glassman, Giedion, and Smith 2017; Shekh Mohamed et al. 2022; Wright and Holtz 2017). Some crisis countries established EPHSs as part of donor funding programs, whereas others aimed to secure the delivery of a minimum set of basic primary health care services delivered by the private sector

or nongovernmental organizations. Most of the packages discussed in this volume were developed mainly as part of national efforts to achieve UHC. Almost all of the packages have significant challenges in the transition to implementation for several reasons: some are unaffordable, cannot be implemented because of unattended or ignored health system weaknesses, have no clear implementation and monitoring plan, and, in certain situations, were designed without securing government ownership and high-level engagement. It is therefore crucial to ensure that those impediments are addressed during package design by securing national commitment and ownership; by ensuring feasibility, affordability, and sustainable financing of high-priority health services; and by identifying and addressing key health system gaps as part of the design process.

Implementation Plan

The crucial step of developing a comprehensive EPHS implementation plan requires extensive dialogue and deliberation. The plan should focus on communicating the package to various stakeholders, organizing the package by service delivery platforms, identifying additional investment needs (such as infrastructure, human resources, and supply chain management), mobilizing additional revenue, enhancing strategic purchasing, and monitoring. To guide implementation, the EPHS should be linked to other national strategies, guidelines, initiatives, and reforms, including budgeting, provider payment mechanisms, human resources development and management, service delivery platforms, infrastructure investment, standard treatment guidelines, essential drug lists, medical equipment lists, and monitoring and evaluation. Four of the seven DCP3 country translation–supported countries and economies—Ethiopia, Pakistan, Somalia, and Zanzibar—developed implementation plans (Alwan, Majdzadeh, et al. 2023). Each plan's development, however, involved limited stakeholder engagement, making the implementation plan less likely to address the health system constraints that impede EPHS rollout.

Aligning EPHSs to Health System Delivery

One of the key challenges in implementing an EPHS is the weak link between the way health interventions are organized within the package and the way the health system is organized to deliver services. Most EPHSs are organized by diseases or specific interventions, but implementing them requires mapping to the platform that best addresses them and mapping interdependent services and platforms. Interdependent interventions must be reviewed and prioritized together, which often does not happen. In addition, the interventions should be mapped to the input required for the health system to deliver them. Countries face substantial challenges aligning disease- or intervention-specific priority lists to the capacity-building, human and material resources, and organizational and financing elements needed to get services to people. Thus, service delivery considerations should be integrated into package development and critical translational work done to regroup the

packages by service type from the intervention- or disease-focused package lists and align them with health system input needs.

Aligning an EPHS with Health Financing Mechanisms

The EPHS can serve as a tool for advocating for and mobilizing more revenue, reducing fragmentation of financing, reinforcing pooling, and enhancing efficiency through strong strategic purchasing. Attaining those goals depends on the clarity of the design objectives and the process followed. Experience from the low- and lower-middle-income countries' EPHS revisions shows a significant disconnect between the EPHS and health-financing strategies and plans, especially in revenue raising. In most of the countries reviewed, the EPHS has not resulted in a significant increase in the allocation of resources to health (Soucat, Tandon, and Gonzales Pier 2023). That situation could be mainly due to an unaffordable package and unrealistic fiscal space projections, leading to an imbalance between the available budget space and the aspirational package, and inadequate engagement and commitment of political leaders. Aspirational packages developed without adequate participation of key political leaders are less likely to be implemented. Therefore, development needs to include a thorough and transparent discussion about the affordability of the package, the financing sources and mechanisms, and securing political endorsement during the design phase.

Although most countries reported some involvement of the finance and planning sectors, the level and timing of their engagement were not convincingly effective. It is important to ensure the ownership and commitment of beyond-line ministries, such as at high levels like the president or prime minister, parliament, ministerial cabinet, and subnational leaders. The gap in securing an adequate level of engagement and commitment from high-level decision-makers in resource allocation is likely a major cause of the weak link between the EPHS design and the adequate allocation of public funds for package financing.

Furthermore, countries can use EPHS design as an opportunity to consider the introduction of fiscal measures such as taxing unhealthy products like alcohol, tobacco, and sugar-sweetened beverages, which have the double benefit of increasing fiscal space (with the possibility of increasing the health budget) and reducing disease burden. Removing subsidies or taxing fossil fuels—recommended as measures to address both health and climate issues—will require further exploration of the unintended impacts of such measures, especially in low-income settings, and of mitigation measures needed before implementing such reforms. The EPHS is a crucial document for harmonizing benefits, pooling funds, and guiding purchasing agencies on what, how, and from whom to purchase; and it links high-priority services to tailored payment mechanisms for health providers at different levels. Nevertheless, EPHSs are only rarely aligned with ongoing financial reforms in the case study countries, highlighting the importance of guiding budget mechanisms that explicitly allocate funds to priority health services and establish purchase incentives that support service delivery objectives, limit cost escalation, and promote efficiency and quality.

Private Sector Engagement

The private sector plays a substantial role in the provision of health services in many low- and lower-middle-income countries. It has limited engagement, however, in the development and implementation of health policies such as EPHSs, indicating untapped potential. For instance, the private health sector was involved in package design in only two out of the seven countries reviewed in this chapter. The private for-profit sector often operates on self-guided and market-oriented objectives that do not align with public sector goals, including UHC, because of the limited enabling environment, participation, incentives, and regulation. When the private health sector plays a major role in essential health services delivery, implementing the EPHS without involving the private sector is unrealistic (Siddiqi et al. 2023). Thus, governments need to comprehensively map the extensive and heterogeneous private sectors by their characteristics (such as nonprofit versus for-profit, service domain, level and type of specialty, geographical distribution interest, and power dynamics) and define the roles they can play in EPHS design and implementation. Identifying and providing key incentives to gear private sector objectives and interests toward UHC are key, as are addressing key barriers related to governance, regulation, accountability, contracting, performance monitoring, and quality of services. This process should be guided by existing evidence and local and international experiences and lessons.

Monitoring and Evaluation

A monitoring and evaluation (M&E) framework that aligns with the existing national health information system is essential for evaluating progress and making timely revisions to an EPHS. The UHC policy process needs to incorporate M&E plans right from the start. Those plans should also align with the global monitoring framework for UHC building from SDG indicators 3.8.1 and 3.8.2 on service coverage and catastrophic expenditures, respectively. The M&E framework should include a combination of those two global indicators and a set of dynamic, country-specific indicators that assess EPHS implementation along the timeline of SDG Target 3.8 (Alwan, Yamey, and Soucat 2023). The country-specific indicators can measure policy availability, resource availability, health system preparedness, service availability, coverage, equity, efficiency, and financial hardship in accessing health care. Some of the countries reviewed in this chapter developed an M&E plan by integrating it into the overall M&E system, but with differences in the types of indicators and the data source. For example, the M&E framework in Ethiopia relies heavily on population-level surveys, whereas other countries use routine data-based monitoring (Danforth et al. 2023).

Institutionalization

Revising a health benefits package is a dynamic process that changes over time with varying demand, health system capacity, and fiscal space. Thus, countries need to put in place a system for institutionalizing regular revision of the EPHS as

a whole or in part. The institutionalization process requires interventions such as establishing and strengthening institutions and governance platforms, developing a legal framework and guiding documents, generating routine evidence and analytics, developing a robust knowledge management system, and securing funds. Despite efforts by the focus countries to establish political will and commitment, a governance structure, an accountable body, a road map to guide the design process, and a method for documenting the process, they still need to do more to establish a legitimate, transparent, and regular revision of their EPHS.

CONCLUSION AND KEY MESSAGES

In general, substantial improvement has been observed compared to earlier efforts in terms of laying the foundational work for priority setting, stakeholder engagement, evidence synthesis, technical capacity, and EPHS design processes. However, experiences in countries also reveal significant weaknesses in the design and implementation of UHC packages (such as feasibility, affordability, alignment with service delivery, financing, and health system readiness), which can unfortunately impede any meaningful progress to their implementation. Despite countries' limited experience in implementing an EPHS, a successfully designed package will generally address the main causes of failure to move to package rollout and will facilitate implementation. Addressing weaknesses and gaps by meeting the requirements and prerequisites covered in the framework for action presented in box 1.1 will provide better prospects for implementation and accelerated progress to UHC. Two of the five components of the framework relate to the initial situation analysis, including the level of political commitment and the state of the country's health system. The remaining components focus on other areas of the package development process and implementation, particularly those related to the requirements necessary for the transition from package design to implementation.

These areas are also covered in the following key messages emerging from the DCP3 country translation review and addressed to policy makers in low- and lower-middle-income countries:

- Countries must execute and own the process of setting and revising an EPHS. Packages developed without adequate engagement of national authorities are less likely to be implemented.
- Requirements for a successful outcome are sustained high-level political commitment, effective engagement of key stakeholders, health system readiness, affordability, committed funding, and strong leadership for implementation.
- Early, committed engagement of the government's planning and finance sectors is essential—investing in package development has limited value without a realistic financing plan.
- Even a perfectly designed, affordable package has no major impact without adequate and well-trained human resources to deliver effective services, including a clear role for the private sector.

- Sustainability for implementing UHC packages requires leadership, political stability, sustained resources, and institutionalization of technical and managerial capacity.
- Low- and lower-middle-income countries need reinforced technical assistance in UHC-related programs, including through regional institutions.

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NOTES

1. This chapter uses *EPHS* and *health benefits package interchangeably*.
2. University of Washington, Department of Global Health, "DCP3 Country Translation Project," https://www.dcp-3.org/translation (accessed August 20, 2023).
3. WHO, "UHC Compendium" (database), https://www.who.int/universal-health-coverage/compendium (accessed August 22, 2023).

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