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ESSENTIAL HEALTH SERVICE PACKAGES:
Uses, abuse and future directions

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Research and Assessment

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INTRODUCTION

"Essential packages" or "core services" can be defined as health service interventions that are considered important and that society decides should be provided to everyone. Values such as equity, cost-effectiveness, transparency and solidarity explicitly or implicitly underlie these concepts.

This paper examines some examples of packages and core services in both developed and developing countries On the whole, most countries that have tried to define and implement packages of services have not been particularly successful; a number of uses and abuses of the packages concept are identified from these examples and from overall experience of work in this field. The final section identifies four future strategies for achieving the objectives of packages in developing countries: the assessment of what is already there to build on; the use of a system wide approach; the strengthening of leadership, and the support of "learning-by-doing".

A close look at examples of packages

Regardless of terminology, the concept of core health services or functions has a long history. Winslow [1] defined public health as the organized effort to improve health through five broad actions (Box 1).

Box 1. Winslow's package

1. Environmental sanitation.
2. The control of communicable infections.
3. The education of the individual in personal hygiene.
4. The organization of medical and nursing services for the early diagnosis and preventative treatment of diseases.
5. The development of the social machinery to ensure a standard of living for everyone adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity.

In 1978 the Alma-Ata Conference on Primary Health Care [2] recommended that PHC should be a holistic approach that would include at least eight elements (Box 2). Some individuals and groups have contended that the list is too long for countries with limited resources and have advocated "selective" PHC implementation [3]. Others have vehemently disagreed with this narrow approach and expressed concerns about the misuse of economic techniques [4-7]

Selective implementation, which threatened PHC in the first years, was gradually abandoned in the mid-1980s with the growth of district health systems as units for the implementation of PHC. The debate has resurfaced again, and become heated, with the development of disability-adjusted life-years (DALYs), a quantitative tool that permits a comparison of the cost-effectiveness of various health interventions as a basis for decisions

on essential health service packages.

Box 2. PHC Elements

1. Education on prevailing health problems and methods of identifying, preventing, and controlling them.
2. Promotion of food supply and proper nutrition.
3. Adequate supply of safe water, and basic sanitation.
4. Maternal and child health care, including family planning.
5. Immunization against the major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases and injuries.
8. Promotion of mental health and provision of essential drugs.

EXAMPLES OF PACKAGES IN DEVELOPED COUNTRIES

Norway

In 1987 the Norwegian Government Commission(8) ranked diseases into four groups based on gravity and benefit of care, and a group termed O-priority, which contains treatment methods of no or negligible benefits. The result of this work is a series of policy guidelines.

Oregon, USA

The decision of Oregon State in 1987 to remove Medicaid coverage for the cost of organ transplants (bone marrow, heart, liver, pancreas) attracted a lot of criticism in the media, particularly after the death of a boy with leukaemia who had not been provided with treatment. A Health Service Commission was formed in 1989 to advise how priorities might in future be established within the Medicaid Programme. While the initial list of priorities drawn up was based on cost-effectiveness data, it soon became clear that scientific data alone were inadequate for this purpose. The Commission turned to professional judgements of the effectiveness of different treatments and also sought the views of the public to develop a list of Medicaid conditions and corresponding interventions in ranking order of priority. The debate continues (9-13), and the issues raised include the following questions:

- How can a clinical decision be based on "an average" of patients without considering the possible benefit to an individual?
- How effective is the consultation with the public?
- Are the perceived needs of marginalized minority groups taken into consideration?

The Oregon list has been described as a "desperate attempt to resolve fundamental problems in a fragmented medical system" [14], and it has been dismissed as irrelevant to the National Health Service in the United Kingdom[15]. Because so many value judgements were involved, it is not clear how the final list was arrived at. All would agree, however, that Oregon has tabled the issue of priority-setting at the political level.

Netherlands

The Dunning Committee on Choices in Health Care was established in 1990 to provide advice to the government on priorities in the reformed Social Insurance System. Underlying the Dunning approach was a conviction that explicit priority-setting was essential if health care was to be guaranteed to all and that certain medical conditions would have to be excluded from insurance funding.

The report [16] provides four questions for deciding what should be included in the package, namely:

(i) Is the care necessary, according to the community approach?
(ii) Is the care effective?
(iii) Is the care cost-effective?
(iv) Can the care be left to individual responsibility?

The four criteria have been popularized as four sieves of a funnel (Fig.1).

The Committee gave a number of examples but fell short of producing an Oregon-type list of services, to be funded. Essentially, the Committee has produced a strategy for making choices based on the community approach. The strategy has been endorsed by the government, but several issues are still being debated, e.g. whether fertility techniques and abortion should be in the package.

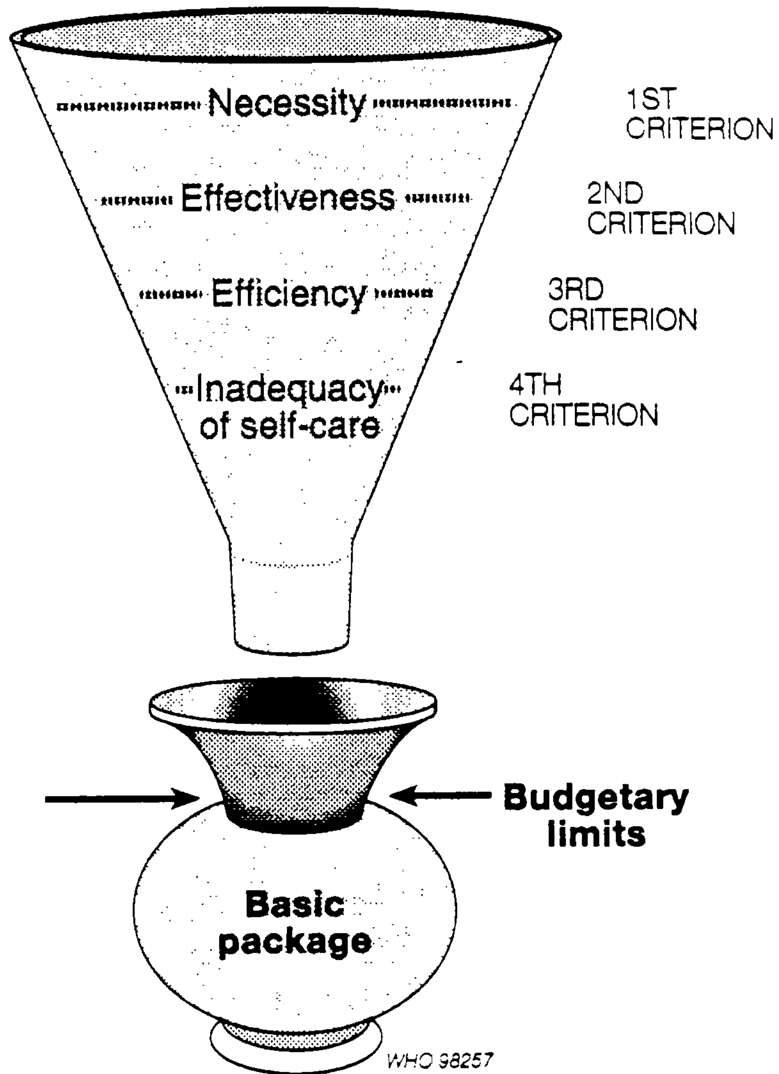
New Zealand

Health care reforms introduced in the early 1990s focused on managed competition in health care. Four regional health authorities took over the health care purchasing role, and it was feared that lack of clarity about the services to be provided by decentralized authorities could lead to resources being directed to publicly visible areas such as elective surgery rather than to less glamorous but perhaps more beneficial services. There was also concern about differences in the availability of services in different parts of the country.

A Core Services Committee was appointed in March 1992 to define a core of health and medical services to be included in the public health services. The Committee consulted widely through questionnaires, surveys, and public meetings. Many consensus-building conferences were organized, each bringing together professionals and lay people, e.g. representatives of disabled people and of Maori communities. The Committee considered the Oregon approach to be inappropriate for New Zealand. There was considerable disquiet about the notion of an explicit core but there was strong support for a broad definition of

services within which regions could determine their priorities. The ability of a core to reflect different cultural needs was a particular concern. The Core Services Committee came out with recommendations [17] that have been used by the government to develop guidelines which have been widely disseminated. The Committee has been maintained, and each year the government considers its advice and incorporates it into policy guidelines indicating what the government expects of purchasers. For example, in the 1994/95 policy guidelines, the regional health authorities are expected to give priority to child health, Maori health, mental health, and physical environmental health (water, hazardous substances and food).

Fig. 1 Basic package through"sieves of a funnel" approach



Sweden

The Swedish Parliamentary Commission on Health Care and Medical Priorities was established in 1992. Its terms of reference were broad and included the need to: "highlight fundamental ethical principles which can furnish guidance and form a basis of open discussions and prioritization in health and medical services".

The Commission critically reviewed relevant work both within and outside Sweden [14] and provided guidelines for priority-setting at the political/administrative level and at the clinical level (Tables 1 and 2).

Table 1. Sweden - Political/Administrative prioritization

Priority group	Content of care
I	Treatment of life-threatening acute diseases and disease which, if left untreated, will lead to disability or premature death. Treatment of severe chronic diseases. Palliative terminal care. Care of diseases that have led to a reduction of autonomy.
II	Population-based prevention and health screenings of documented efficiency and cost-effectiveness. Individualized prevention and habilitation/rehabilitation, together with the provision of aids that are not integral parts of the care.
III	Treatment of less severe acute and chronic diseases.
IV	Care for reasons other than disease.
V	Self-care. Minor ailments

Table 2. Sweden - Priority groups in clinical activity

Priority group	Content of care
IA	Treatment of life-threatening acute diseases which, if left untreated, will lead to disability or premature death.
I	Treatment of severe chronic diseases. Palliative terminal care. Care of diseases that have led to a reduction of autonomy.
II	Individualized prevention and habilitation/rehabilitation, together with provision of aids that are not integral parts of care.
III	Treatment of less severe acute and chronic diseases.
IV	Care for reasons other than disease.
V	Self-care. Minor ailments.

PACKAGES IN DEVELOPING COUNTRIES

Methods of selecting priority diseases based on the extent of morbidity and mortality and the feasibility of control have been suggested recently. Using these methods, diseases in developing countries have been divided into three groups. Group I contains the infectious diseases, such as measles and diarrhoea, that cause most of the preventable illnesses and deaths. Groups II and III contain, respectively, health problems that are less pressing and those that are more difficult to control. It has been recommended that interventions concentrate on Group I diseases and that research be carried out on the diseases in Groups II and III to develop less costly and more effective methods of prevention and therapy [3].

A quantitative tool that has recently been developed permits a comparison of the cost-effectiveness of various health interventions[18]. The process begins with a measurement of the burden of disease in a country in units of disability-adjusted life-years (DALYs). Next, the cost of achieving one additional DALY is computed. The computation has been confined to major interventions. While the DALY has been proclaimed to be the fourth most important public health development in recent years,[19], debate on its usefulness and limitations is extensive [20, 21].

However, quantifying the burden of disease gives the tool a precision that is lacking in the selective PHC approaches [22] of classifying diseases into groups I, II, and III. The tool also makes it possible to include in the priority list important interventions that deal with aspects of Groups II and III diseases. A number of countries, with support from donor agencies are developing packages of priority health services. The list of countries with an interest in designing such packages is long and includes Colombia, Eritrea, Ethiopia, Ghana, India (Andhra Pradesh), Indonesia, Kenya, Mauritania, Mauritius, Mexico, Tanzania, Turkey, Uganda, Uruguay and Zambia [23]. But, in practice few of these countries have yet implemented them. In some of these countries the package is but a summary of the efforts made to improve district health systems. Cambodia has taken the view that essential health care packages cannot be easily designed in the classic WDR 1993 model. Examples of packages in four countries that have made notable progress are highlighted below. They illustrate some of the issues that have been raised by the conception and implementation of Basic Packages in low-income countries.

Mexico has developed basic packages of care to cover the low-income population that is, at present, excluded from formal health insurance. It aims to cover low-cost, high-impact interventions with an emphasis on health promotion and preventive measures. It is designed to build on the experience of existing programmes and uses a horizontally integrated approach. The package is seen as the irreducible minimum that must be provided nationally but there is scope at regional level for added services. There are 12 essential areas of intervention, each with specific strategies (Table 3). Catastrophic conditions are excluded: AIDS, major trauma, cancer treatment, and most tertiary level services will not be covered. Basic surgery such as appendicectomy, tonsillectomy and caesarean section are included, however [24].

Colombia [25] is undertaking a similar process (Table 4).

Bangladesh has an essential services package consisting of four health care components, related to the major goals of the health sector[26]. It has been organised primarily with the rural population in mind, and defines which activities should be carried out at each level of the health system, from community and outreach services to district hospital level. A matrix format lays out the activities for each of the interventions (Table 5).

Zambia has developed further [27] with its matrix of identified and costed activities, possible indicators and data sources (Table 6). The level and frequency of data collection have also been established, providing a step towards monitoring and evaluation of the packages approach.

Table 7 indicates the nature of packages in the nine countries analysed.

Table 3. Mexico: Basic Package Interventions:

Intervention	Community level	Primary level	Secondary and tertiary levels
Basic sanitation for the family	Disinfection of water, sanitary disposal of excreta, health education.		
Effective management of diarrhoea in the home	Training of mothers, distribution of ORS, referral for treatment.	Treatment of complications.	Under 1 year only.
Antiparasitic treatment	Health education.	Treatment with antiparasitic drugs.	
Management of ARI	Training of mothers.	Specific treatment, and referral.	Serious pneumonia in children under 1 year only.
Prevention and control of TB	Health education.	Referral of patients with chronic cough.	Supervised treatment of cases and contacts.
Prevention and control of diabetes and hypertension	Health education.	Detection and health education, supervised treatment.	
Immunization	Health education.	Vaccination.	
Monitoring of child growth and nutrition	Training of mothers, nutritional guidance.	Detection of problems and diagnosis, referral and follow-up.	
Family planning services	Health education.	Distribution of contraceptives.	Referral for IUD, tubal ligation, and vasectomy.
Childbirth	Promotion of breastfeeding, health education.	Antenatal consultations, administration of tetanus toxoid and iron, referral of high-risk pregnancies and deliveries. Immediate care of newborn, treatment with BCCG and polio vaccine.	Management of high-risk pregnancies and deliveries, management of newborn infants with problems.
Prevention of accidents and initial management of injuries	Health education.	First aid and referral.	
Community participation	Local health committees, protection of drinking-water, sanitary waste disposal, promotion of food production, etc.		

Table 4. Colombia: Basic Package Interventions for uninsured, low-income population

Intervention	Community level	Primary level (outpatient)	Primary level (inpatient)	Secondary level
Public health promotion and prevention programmes:	Covered	EPI. Growth and development monitoring of children. Prenatal care, breast examination, and cervical smears for women.		
Treatment, e.g ARI, minor wounds, skin diseases, etc.		Basic treatment of wounds, burns and fractures; treatment of endemic diseases and ARI. Referral for appendicitis and serious burns and wounds. Treatment of parasites in children. Treatment and referral of hypertension, urinary tract infections, diabetes, STDs prostate problems, gastrointestinal bleeding and ophthalmological problems. Treatment and referral of cervical cancer and prolapse. Tubal ligation and vasectomy.	Treatment for diarrhoea and ARI in children, Treatment for malaria, leishmaniasis, dengue yellow fever, leprosy and TB for all ages. Basic treatment of wounds, burns, and fractures. Low-risk deliveries.	Serious pneumonia, meningitis and diarrhoea under 1 year. High-risk pregnancies and post-partum complications. Surgical interventions such as tonsillectomy, Cesarean section, and cholecystectomy. All tertiary level services and "catastrophic" illnesses excluded, e.g., major trauma, cancer, HIV/AIDS*
Dental care		Fluoride treatment for children. Diagnostic examinations, treatment, education and emergency care for all ages.		

* The insured population remains covered for all surgical services, including those at tertiary level, and also for catastrophic illnesses, including organ transplant and treatment of congenital malformations.

Table 5. Bangladesh: essential services package*

Intervention	Community or outreach	Health and family welfare centres	Thana health centres (first referral level)	District hospital (secondary referral level)
Child health e.g EPI, prevention and control of ARI, diarrhoea, malaria and measles. Integrated management of the sick child.	Mobilization of carers, referral, EPI outreach, Vitamin A supplementation. First-line treatment for diarrhoea, ARI, etc.	As for community level, plus referral of severe cases and treatment for dysentery.	Service delivery planning of preventive programmes such as EPI. Management of referred cases, hospitalization as required.	Management of very severe cases.
Reproductive health maternal health, family planning, adolescent health, prevention and control of STD/HIV.	Antenatal, delivery and postnatal care, promotion of breast feeding and family planning methods. Counselling, condom supply, referral etc.	As for community level. IUD services, and some surgical contraceptive services (10%)	Surgical contraceptive services.	As for Thana health centre. Laboratory diagnosis and management of STDs. Complicated obstetric care.
Communicable disease control: TB, leprosy, malaria, kalaazar, filariasis, and intestinal parasites.	Mass campaigns against filariasis, worms, etc., vector control, surveillance, early recognition and treatment of malaria. Mobilization and defaulter tracing, referral.	As for community level. Management of malaria where treatment has failed.	Diagnosis and treatment of TB, leprosy, etc., referral of complicated cases.	As for Thana health centre. Maintenance of reserve of stocks, logistics.
Limited curative care: Treatment of common conditions, and medical emergencies.	Basic first aid, transport for referral.	First aid, identification and treatment of common conditions (e.g. impetigo, scabies, common cold); referral of severe cases.	Management of severe cases.	Management of severe cases.

* No age limits specified; aimed primarily at the rural population (80%).

Table 6. Zambia: Packages

	Malaria	Diarrhoea	Diabetes	AIDS	Malnu-trition	MCH	EPI, TB	Hypertension	Family planning
Community	Impregnated bed nets	ORS. Prevention.		Distribution of condoms	Growth monitoring. Deworming. Iodized salt.	TBA for uncomplicated deliveries. Follow -up of at-risk pregnancies.	Home care.		Advocacy. Provision of oral contraceptive pills and condoms.
Health post	Case management	ORS (mild cases).		Home-based care. Condoms.	Screening. Monitoring. Treatment with mebendazole.	Risk screening training and supervision of TBAs.	Home care. Contact and defaulter tracing.		Counselling. Provision of oral contraceptive pills, condoms, injectables.
Health centre	Laboratory diagnosis. Treatment with Fansidar doxycycline.	Laboratory diagnosis ORS intravenous.	Laboratory diagnosis Review Supply Insulin and orals	Laboratory diagnosis. Screening. Treatment of symptoms. Counselling.		Delivery of high-risk pregnancies. deliveries (Lidocaine, Ergometrine screening of STDs in ANC).	Laboratory diagnosis. Treatment.	Case management with hydrochloro-thiazide. Follow-up.	Counselling. Provision of oral contraceptive pills. IUDs, injectables.
First referral	Microscopic diagnosis. Treatment with quinine intravenous.	Microscopy/ and culture. Intravenous, ORS, Nalidixic acid and intravenous fluids.	Treatment of complicated cases with insulin, blood, glucose	HIV Tests, intravenous fluids. Treatment with ketoconazole, immodium etc.		Caesarean section, surgery, blood transfusion.	Radiology.. Laboratory diagnosis. Treatment of TB compli-cations.	Radiology. Treatment with methyldopa.	Counselling.

Table 7. Nature of the packages in nine countries

Country	Mechanism	Nature of package
Norway	Norwegian Government Commission (1987)	Policy guidelines
USA, Oregon	Health Service Commission 1991 and 1993	List of medical conditions and corresponding interventions in order of priority
Netherlands	Dunning Committee on Choices in Health Care (1990)	Guidelines and examples of "exclusion"
New Zealand	Core Services Committee (1992)	Recommendations incorporated in guidelines
Sweden	Parliamentary Commission on Health Care and Medical Priorities (1995)	Guidelines for macro- and micro-levels
Mexico	Department of Health	List of interventions in several areas to cover low-income population without insurance
Colombia	Ministry of Health	List of interventions in several areas to cover low-income population without insurance
Bangladesh	Ministry of Health (1997)	List of interventions to be carried out at various levels of service
Zambia	Ministry of Health (1996)	List of interventions to be carried out at various levels of service

USES AND ABUSES OF PACKAGES

This section focuses on the use of packages in developing countries and discusses the positive and negative features of their use to date.

The merit of the package approach is that the process of priority-setting is explicit. Thus, the approach encourages public debate about prioritization and the rationing of health care. As packages are based on an assessment of the cost-effectiveness of various interventions, they should improve efficiency in the allocation of resources. The establishment of packages also theoretically limits the variation in availability of services in different parts of the country. Other potential benefits of packages are that providers of services, including insurers, cannot define packages of services in such a way as to exclude those at high risk. The allocation of resources is not based just on political criteria with priority going to publicly visible activities. This should enhance transparency and accountability in decision-making. The tool is also an innovative approach for marketing priorities, however, these advantages have yet to be realized in many countries.

While it is acknowledged that essential packages can aid decision-making by providing useful information, confusion has arisen through their presentation as "products", ready for testing and implementation. It is now increasingly recognized that this "quick fix" claim is presumptuous and wrong - an abuse of the concept of packages. Although the package description gives a clear outline of the tasks to be performed by health workers at each level, there is no elaboration of *how* this is to be organized. The tables and matrix do not cover the necessary referral structures and staff supervision, nor the regulation, monitoring and evaluation of services. Reference is made to existing protocols, but there are no new strategies to improve case detection, health promotion activities, the quality of care, or organizational management. Much of the exercise appears to have been drawing up task lists, which merely reflect the services that health workers should be providing at present. The real problem, however, is not that administrators are unaware of what needs to be done but rather they do not know how the required standards can be reached, in view of the inadequate functioning of the system.

Some other problematic issues are common to the four developing-country examples given above. The question of what happens when intervention or treatment *outside* the package is requested has not been addressed. It is assumed that people will have the choice of alternative providers, which in many developing countries, especially in rural areas, is not the case. The package appraisal also seems to concern itself solely with the direct costs of health services, while the social costs (for example, those involved in travel to seek health care) are excluded.

Although the package concept is described as a way of improving coverage for the poor, no equity indicators are mentioned. The process of defining packages has been criticized for failing to provide information on the extent to which various interventions benefit the poor rather than the rich and to identify those that people are able and willing to pay for [28].

Another problem has been the presentation of the package tool as scientific when it is actually full of value judgements. Priorities are determined by "guesses" about effectiveness and social judgements about "reasonableness". The content of packages are to a large extent dependent on approaches and values used.

The package, like selective PHC, is of greatest benefit to the very young and those with short-term problems. Yet to understand and to be able to act on the problems of children it is essential to see them as part of families and communities. The demographic and epidemiological transition is increasing the proportion of chronic and adult disease in total morbidity and mortality in developing countries. The package (and selective PHC) approach of lining up diseases and problems and then attacking them one by one, or in groups, will not work. Policies should focus on overall populations, including the low-risk majority, and take intermediate and long-term perspectives. Most packages, despite the impression created by the name, do not respond in a holistic manner to the needs of society as a whole - the young, the old, the family, the unemployed, and the community. What is required is an active holistic approach in which essential interventions for each of the eight elements of PHC are carried out within the constraints of available resources. This strategy integrates short-term and long-term action.

There are essentially two levels of priority-setting - the macro-level (policy, strategy) and the micro-level at the interface between front-line health workers and individuals, families, and communities. Many packages are misleading because they do not indicate the level of focus.

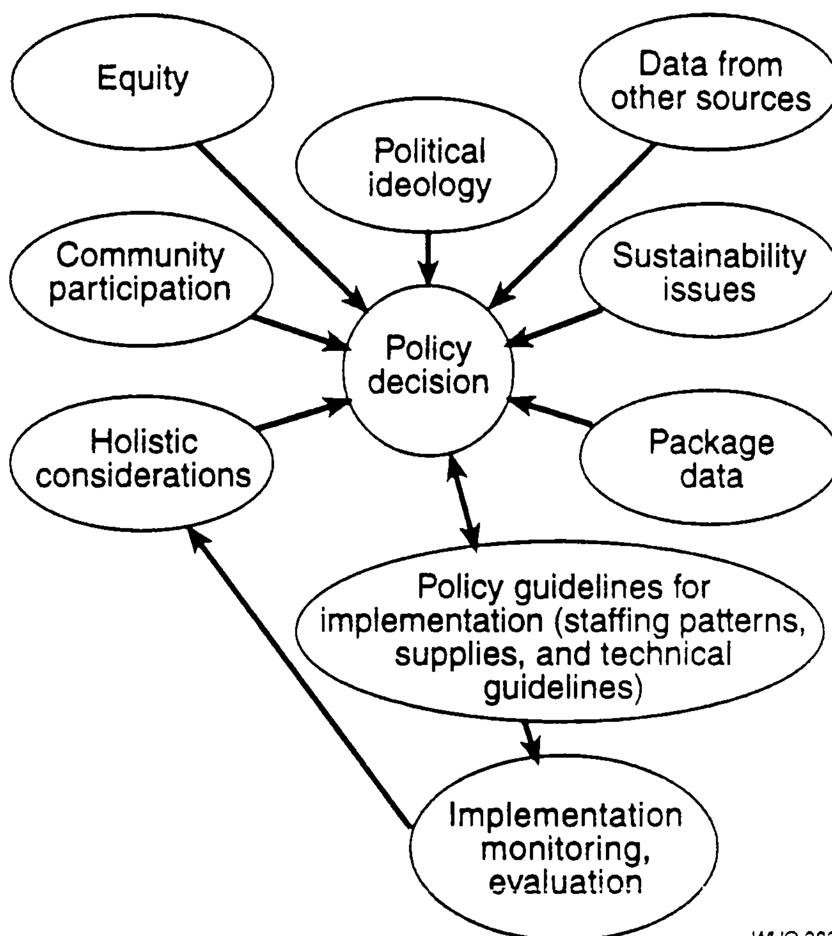
An examination of the "products" of packages shows clearly that packages could have been arrived at through simple, cheap methods using existing data (e.g., routine statistics and demography and health surveys) and local knowledge. It could be argued that more extensive data is not worth the bother of collecting [25].

One has the impression that packages are often seen as a substitute for weak leadership. It is difficult to see how a mere process or a package will solve problems where there is no vision, strategy or leadership. Politicians and decision-makers often try to avoid difficult choices by calling for more data and/or decentralization. Thus the call for packages and investment may even provide credibility for "business as usual" where there is no political will or strong leadership to make essential but difficult decisions. In this respect the package can be seen as a form of "painless PHC". This brings us to a paradox. In countries where strong leadership and management capabilities are present, formal packages are probably irrelevant because policies, strategies, and activities to ensure that all population groups enjoy access to health care have been incremental and successful. The package is a "big bang" tool that might be used in other countries to advocate needed policies and

leadership, but there is little practical evidence of this happening. However, the package data may provide decision-makers with information that can be used along with information from other sources, in making policies (Fig. 2). A good example of this is the use of data from the Core Service's Committee of New Zealand to develop guidelines for health care.

Finally, what happened to community empowerment and participation? In one country example, community participation is presented as one of the twelve interventions, rather than an integrated coherent part of the whole. There does not appear to have been any community participation or public involvement in the determination of package contents, nor any attempt to assess what people on low-incomes *themselves* see as priority concerns. Cross-sectoral collaboration and ways of ensuring a consumer voice in the process of decision-making and implementation have not received serious attention. From other examples of packages, we read about "consultation" with the public. Debate continues on how best to bridge the gap between professionals and the public in terms of priority choices[29-34]. The PHC approach is about advocating and supporting communities to assess their needs, decide on priorities, implement activities, and monitor progress. The relative neglect of the need for community participation and intersectoral action in the construction of packages poses an obstacle to the implementation of primary health care along the lines envisaged by the Alma-Ata Conference.

Fig. 2. The package as an aid to decision-making, as one of many inputs



FUTURE STRATEGIES

The issue is not whether prioritization should be carried out or not. Health demands always outstrip available resources. Indeed, gaps between needs and available resources have increased considerably, particularly in developing countries. With inadequate health budgets, salaries, and incentives and with grossly inadequate supplies, the quality of publicly funded health care has deteriorated in many of these countries. In the circumstances, public facilities have lost credibility and those who are able to pay turn to private sources of care where available. This dilution of quality and standards is a form of priority-setting but an unacceptable one. Something different has to be done: the challenge is *how* to do it, building on experiences both positive and negative from work already done on essential packages and other activities. Debate on explicit versus implicit priority-setting is extensive. Implicit rationing of services at local level is claimed to be practical and a way forward [(35)]. Others, however, disagree and see such an approach as "muddling through".[36,37]

What is clear is that simple prepackaged, cookbook models that fragment care are not the answer . There are no short cuts. Models that recognize the diversity of families and communities and their needs and that build on holistic, intersectoral approaches are the way forward. In the following sections, four approaches are proposed that could lead to strategies defining the future direction of primary health care.

1. Start with "What is there to build on?"

Existing structures and available human resources provide a practical basis for deciding on priorities for improvements in health care.

The process of developing packages requires a cost-effectiveness analysis of various interventions to identify the "best buys". This requires a huge number of studies and resources, for it is not just a question of analysing the cost of numerous possible interventions but also of possible mixes. Is all this necessary? As packages should be linked to the possibilities for action, pragmatic approaches to setting priorities that are developed in the context of existing structures and staffing are recommended for the future. Many developing countries have already built up sound structures, organizational arrangements, and basic budgets, and these are unlikely to be changed in the near future. They have also taken measures to strengthen first-level referral institutions. Moreover there are many aspects of existing services that are more or less a given, such as maternal and child health and the control of diseases. Innovative organizational arrangements have been developed; for example, many countries are moving from providing separate vertical services, to using one point of contact with the health service and working from that point, (usually around MCH) and often referred to as the "supermarket" approach.[38] Priority-setting which is based on "given realities" requires only modest data.

Once staff have been employed and services organized, there is very little to be gained by being very selective, along the lines being suggested by many priority-setting studies and packages. Priority-setting should be much more concerned with the efficient use of health workers' time. The relative overstaffing of some health services, which becomes

obvious on visiting health centres and hospitals means that there is staff time that can be deployed for activities that do not require additional supplies. In the long run it may be possible to achieve a more appropriate allocation of resources between salaries and other costs (in Africa, south of Sahara, 60-80% of the recurrent budget currently goes on salaries), and appropriate strategies to this end should be developed. However, little change is likely in the short term. Again studies that take the existing structures and staffing pattern as a given are likely to be both less costly and more practical. Priority-setting is in this respect, an incremental process. It is theoretically possible to reallocate resources, but in practice this is difficult or practically impossible where there is no growth in the health budget.

It is interesting to note that the content of packages is almost identical to what front line and first-level institutions are presently being asked to do. In fact, when those who have been involved in the development of packages are asked what should be *eliminated* from the present functions of health centres, the answer is usually silence! A number of initiatives have evolved in a similar way: the Bamako Initiative, for example, which started as a community financing scheme [39], gradually evolved to include the concept of cost-effective minimum care packages through revitalized health centres. Coupled with district strengthening, rationalization of resource use and management, community outreach and cost-sharing, the end result of the Bamako Initiative, in practical terms, amounted to the implementation of primary health care. This leads to the logical conclusion that in looking at the implementation of packages, there is a need for a broader "system-wide" approach.

2. A system-wide approach

Four issues are discussed under this section. First, besides the need to build on what already exists, priority setting in future should go beyond the provision of cost-effective health care. It must be concerned with mobilizing additional resources, financing, and the delivery of health care and impacts on health (see Box 3). Priority-setting at each level of the health system has to be concerned with both the goal and the means [40]. The former does not necessarily justify the latter.

Secondly, it is necessary to consider what the term "package" means in a system-wide approach. The content of the package can be almost anything, when applied to a health system. For example, a health care package has been defined as "an integrated set of components for the improvement of health care under specific socioeconomic conditions"[41]. The same authors add that if the word "system" were not so overworked it might have been used instead of "package". As used in the examples cited in this paper, the concept of packages might be better captured by the concept of standards or quality assurance in health care. This evolution of the term "package" is already taking place in a number of countries, explicitly or implicitly.

In this context, the challenge is to define common standards of care that will enable everyone to live a socially productive life within available resources. How can this be done? An important step is to decide on a basic set of values to serve as criteria against which progress can be assessed. In addition, standards need to be assigned to each level - resource allocation, organizational management, services delivery, output, and impact. Basic

indicators are required to permit monitoring of the implementation of the package.

Thirdly, a serious deficiency with many packages is a lack of clarity in the values used in defining them. Often there is one predominant criterion used as a basis for decisions (e.g., cost-effectiveness).

Box 3. A system-wide approach

Macro-level	Development and allocation of resources	Health allocation ratio. Allocation of resources between different types of health institutions (hospitals, health centres, health posts, etc.), between different geographical areas, and between the infra-structure, technical programmes, and population groups.
	Donor agencies	Effective donor coordination.
	Human resources	Mix of different categories. Basic and continued education. Motivation.
	Organization and management	Decentralization. Public private/mix. Empowerment of communities. Partnership with local institutions.
	Financing	Options and coverage.
Micro-level	Provision of care (local)	Promotive, preventive, curative mix. Choice of what treatment a patient gets. Decision on how much is spent on individual patients.

Box 4 shows the range of values on which the priority-setting process in some of the countries examined in this paper was based. Most countries explicitly emphasize the importance of equity, although this was not the case in Oregon.

Box 4. Examples of values in priority-setting for health care

New Zealand	Effectiveness, value for money, fairness, consistency with national values and priorities.
Oregon	Value to society, value to the individual, importance to basic care.
Sweden	Human dignity, solidarity, cost-effectiveness (subordinate to the first two).
Netherlands	Necessity for service, effectiveness, efficiency.
Developing Countries	DALYs saved, cost-effectiveness, political criteria (such as those decided on by the government or agreed with donors).

Box 5 shows a framework of continuous priority-setting and quality assurance[42]. Priority-setting is essentially an incremental process in response to changes in social attitudes, demography, economic situation, and technology. The concept of continuous quality improvement links well with priority-setting[43].

Fourthly, the extent of coverage must be considered. Are packages seen as a "safety net"- i.e., a small public system to care for the poor and indigent who cannot pay in a predominantly private system? Or, do they provide a service for most of the population with an "escape valve" of a small private system for the rich and non-nationals? It is obvious that if the existing resources in the country are viewed overall, as in the second option, it would be possible to provide more than the basic package for the total population. The amount of public funding that should be reserved for a small elite group is an issue arising for both options. Donabedian [44] has polarized the ideological basis of the two approaches and called on politicians and decision-makers to indicate their choice explicitly, but many countries have not done so.

In establishing the content of packages, various factors must be borne in mind. National norms are certainly required but, in addition, because the individual's need is specific to each encounter with the health system, there has to be adequate room for discretion at the local level. The complexity of medical decision-making requires flexibility within a framework of national guidelines. In this respect, it is necessary to monitor the implementation of the package to ensure that it is attaining the values on which it is based as well as the stated objectives. This requires indicators to measure aspects such as equity and community participation, which may require disaggregation of collected data by gender, socio-economic group, etc.

Box 5. A framework of values for priority-setting in health care

1. Access to all according to need.
2. Cost-effectiveness.
3. Equity.
4. Technical efficacy and utility.
5. Holistic approach and continuity of intervention.
6. Community participation, client preferences, compliance and satisfaction.
7. Provider compliance and satisfaction.
8. Transparency of the decision-making process.

3. Strengthening Leadership

The macro-level can influence priority-setting at the local level through establishing standards for staffing patterns, equipment, and supplies and of performance in selected areas. The macro-levels should advocate and support capacity building, by providing guidelines on the values decided upon, as was done in New Zealand by the government and by professional associations. But the performance of providers cannot be enhanced just by guidelines; it needs, in addition, changes in work practice and behaviour and a sense of duty, which depends on leadership. The strengthening of leadership mechanisms includes the establishment of high-level national priority-setting and quality-assurance committees to spearhead and coordinate work.

An important leadership function in developing countries is effective donor agency support. But ironically, a major obstacle to effective priority-setting is the donor agencies themselves. Each donor agency is most interested in improving its own tools and advancing its own priorities. For example, ever since the Alma-Ata Conference, when countries adopted the concept of "essential health care consisting of eight elements", donor agencies have been marketing their tools and priorities under various slogans including "selective PHC", "GOBI", "children's revolution", and more recently "packages". While it may be useful for each agency to come out with its slogan to mobilize health action in its area of responsibility, it can be very time-consuming for the country concerned. A moratorium should be put on slogans. Despite the fact that developing countries now have considerable numbers of staff with skill in planning and priority-setting, donor agencies continue to impose consultants with little practical experience. A number of suggestions have been made on how the effectiveness of donor support can be enhanced[45-47].

4. Learning by Doing

There is an urgent need for a new paradigm in priority-setting, which should take the form of a bottom-up approach. However, there are many pressing operational issues for which there are no easy solutions and very little investment has been made in research and analysis of package implementation as yet. This is highly regrettable given the large sums of money available for testing unrealistic tools. Learning-by-doing is the best tool that

developing countries have and the one that best enables them to learn from each other.

The challenge is how to approach the complex structures of health systems and trace the options for the process of priority-setting. The complexity means that quick solutions are unrealistic. An essential first step is to examine the infrastructure of the system: half the least developed countries do not have an adequate infrastructure. This is an obvious initial priority. Health systems must be able to *deliver* the priority services identified, and the process of priority-setting must focus on the structural, organizational, and contextual features necessary for health interventions.

Three issues need special attention. First, the process of priority-setting should encourage people in communities to organize themselves, define their own needs, and implement activities to improve their health, given an appropriate supplementation of services by the government, as envisaged in the PHC approach[48]. The need to show quantitative results and to justify budgets in recent years has resulted in low priority being given to community participation and intersectoral collaboration, which are difficult to measure quantitatively. The concept of community participation needs to be revived, building on innovative ideas that have been developed in a number of countries.

The second issue is that of managing outcomes in an integrated way. The divide between management and technical programmes has been a serious and intractable problem in health services. Priority-setting in this respect should be about choosing mixes of interventions based on the values outlined in Box 5. The third issue is the amount of work that should be carried out under each of the eight elements of primary health care, and how it should be organized to provide maximum output and impact. Special attention should go to addressing the issues of inequity in health and health care. With one or two exceptions, packages developed to date have not been accompanied by a system of indicators and monitoring mechanisms for equity. A number of experiences and recommendations on which countries can build have been outlined [49].

At the macro level, the priority accorded to health, in terms of proportion of government resources allocated, remains low in poor countries [50, 51]. Some of these countries devote a considerable part of their resources to military expenditure. Governments need to find ways to increase the allocation of resources to health and to live up to their commitment to provide essential health care to all. Special efforts are required in the least developed countries, where the prospects of health for all remain gloomy. On present trends, 39 countries will not be able to achieve the World Health Assembly's target of an infant mortality rate of less than 50 per 1000 live births by the year 2020. Ten countries will not have achieved this target even 20 years on [50, 51].

Other research questions that could be addressed include:

- How can different values and sequential problems be included and dealt with?
- How might community and local technical capabilities be enhanced so as to

better identify and lead health action?

- What mechanisms are needed at each level for priority-setting and quality assurance? One idea might be a Ministry of Health council for health care priorities or quality standards.

- What might be the potential of sentinel sites in complementing routine data, in the monitoring and evaluation of the process?

- How can we gain a better understanding of the political realities and policy steps required?

- How are broad macro-level frameworks to be translated into decisions at local level?

- Do priorities actually influence levels of budget?

- How can the process of priority setting be transparent?

- To what extent do other factors influence priority-setting?

Clearly there are many unknown factors, and the need for analysis and comparison of experiences is essential, particularly in studying the extent to which practice measures up to the values aspired to.

It is strongly recommended that a global project be initiated, that would work with, and support, a few developing countries in strengthening the bottom-up approach to priority-setting, and in implementing the other principles outlined in this paper. The work of the project could be grafted on to current efforts by international agencies. The project could be initiated in selected districts in a few countries. The process of priority-setting should build on best practices from projects elsewhere and ensure that an effective, efficient, financially viable and equitable PHC system is established, implemented, and monitored and that the results are disseminated. The learning-by-doing work should result in recommendations that could be used for the expansion of the experience nationwide and to other countries facing similar problems.

SUMMARY

The concept of "essential packages" or "core services" is not new, despite changing terminology. However, the focus on new tools such as the disability-adjusted life-year and the measurement of the burden of disease, have increased interest in defining priorities in health care in terms of efficiency and cost.

In practice, the development of packages has not been the panacea some envisaged: package definition and implementation have often failed to build on existing realities in terms of structures and organization and have inaccurately assessed the system's ability to deliver prioritized interventions.

Priority-setting requires an *explicit* statement of the values on which it is based and these core values require the development of flexible implementation at local level. Choices need to be made about the "safety net" approach, and its implications for equity and *overall* resource allocation in the health sector.

The package approach has been a timely reminder of the relative neglect of standards and quality assurance in many health systems. A change of emphasis, with the package representing the concept of quality standards of care rather than just a list of defined interventions, should be the way forward. The aim should be to build capacity for continuous quality improvement, enabling people at all levels of the health system to make appropriate choices.

Finally, it is clear that there are no short cuts. The need for leadership, an holistic system-wide approach that integrates preventive, curative, and public health activities, and strategies to encourage "learning-by doing" are basic to improving health care and health outcomes.

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