LINKAGES BETWEEN THE ESSENTIAL HEALTH SERVICES PACKAGE AND GOVERNMENT-SPONSORED HEALTH BENEFIT PLANS IN ETHIOPIA

A CASE STUDY

The Health Finance and Governance project
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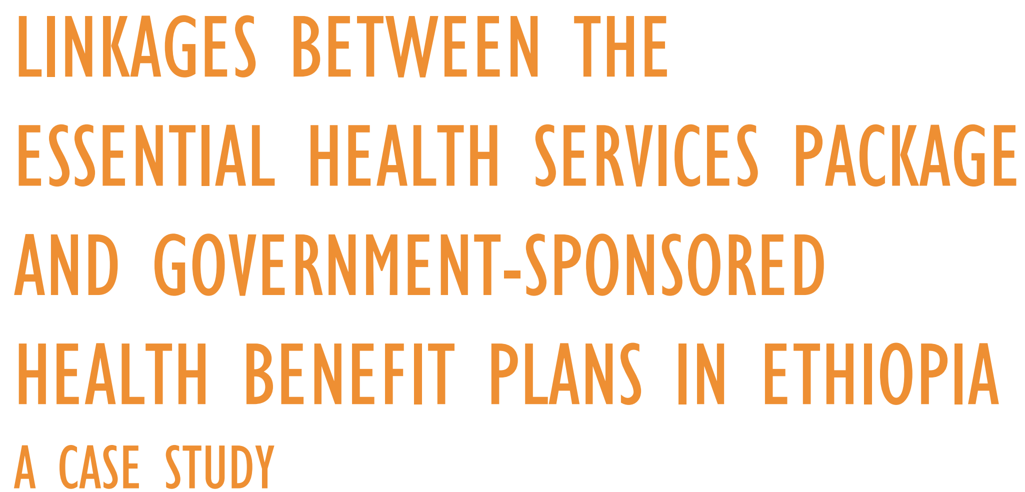

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ACRONYMS

CBHI	Community-based Health Insurance
EHSP	Essential Health Services Package (Ethiopia)
FMOH	Federal Ministry of Health
HFG	Health Finance and Governance project
SHI	Social Health Insurance
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Priority setting is a key function of health systems in low- and middle-income countries that seek to achieve universal health coverage. Essential packages of health services and health benefit plans are two types of instruments used in setting health care priorities. In Ethiopia, the government has experience with both. It created an essential package of health services, called the *Essential Health Services Package of Ethiopia* (EHSP) in 2005. Shortly thereafter, to accelerate the progressive realization of universal health coverage, the government began piloting the first of two major health benefit plans, community-based health insurance (CBHI). It also plans to launch a second health benefit plan, social health insurance (SHI).

Currently, gaps exist in global knowledge about how priority-setting instruments evolve and whether, within a single country, they are aligned with one another. To gain insights into the purpose, policy objectives, and governance of the EHSP, CBHI, and SHI in Ethiopia, HFG conducted a case study in 2016. The study included a desk review of relevant documents as well as qualitative analysis of key informant interviews conducted with 15 leading health finance experts in Addis Ababa.

Interviewees understood that the EHSP has been a key priority-setting instrument in the country. The EHSP is fundamentally linked to a health system designed around universality. The EHSP was described as the basis for strategic planning in the health sector, in regard to developing human resources for health, distribution of health facilities, and other issues. It also is a source document for government decisions on exempting certain services from user fees (that said, not all services in the EHSP are exempted). While both the EHSP and the two health benefit plans effectively prioritize health services consistent with the aims of universal health coverage, interviewees spoke more directly to universal rights when discussing the EHSP. In this way, the EHSP was seen as an essential tool for coordinating the activities of health system stakeholders, and guaranteeing the right to a basic level of care.

Many interviewees suggested that the EHSP should be dynamic and broadly reflect the primary care needs of the population. However, the EHSP has not been legally updated since it was created in 2005. The list of services exempt from user fees, on the other hand, has been more dynamic. Interviewees also suggested that tension exists between the desire to exempt more services from user fees and the need to contain rising health care costs.

CBHI and SHI were described as mechanisms for the government to use in expanding health coverage and providing financial protection to the population for services that still require payment of user fees. Interviewees acknowledged that Ethiopia had drawn on the experience of other countries when designing the health benefit plans, but contrasted Ethiopia's experience with other countries by highlighting a high degree of national leadership and participation. Interviewees also thought that the design and management of CBHI in Ethiopia was more sustainable than in the other countries. Interviewees believed that the benefit packages of both CBHI and SHI were informed by sound financial data on the cost of services to be included in the package.

In Ethiopia, the ESHP, CBHI, and SHI are not explicitly aligned. While interviewees thought that the EHSP influences the CBHI and SHI benefit packages, the links are not explicit. One interviewee thought that clearer messaging of the CBHI benefit package, and how the CBHI premium will provide more coverage for health services beyond those exempted, was needed. Some interviewees thought that CBHI covers all services in the EHSP, but the alignment was not explicit. The SHI appears to be even less aligned with the EHSP given that it covers a broad package of services, including tertiary care services that would likely be unaffordable for the government to cover for the entire population.

It seems plausible that the EHSP, while integral to early health sector reform, has become less relevant as health benefit plans, with their own packages of services, scale up and the health financing architecture becomes more sophisticated. The government is also seeking ways to provide financial protection against catastrophic household out-of-pocket spending on health, which often arise from use of tertiary services that are beyond the reach of the EHSP.

A number of recommendations for country health policymakers, development partners, and others have emerged from this research:

1. Clarify a country's priority-setting instruments by developing a clear and consistent vocabulary to describe services offered, and use this to compare the service package of each instrument.
2. Where multiple priority-setting instruments exist, document how they interact and the rationale underpinning the development of each.
3. Ensure local ownership and governance of priority-setting instruments, and establish a process to routinely update the service package of each to ensure it reflects the changing health priorities and financial reality of the country.
4. Do comparative research to test the idea that the utility of essential packages of health services changes as the health system becomes more complex and develops more sophisticated modes of health financing.

Essential packages of health services play an important role in early stages of health system development. However, as governments develop health benefit plans to reduce household out-of-pocket spending for an ever-expanding package of services, the importance of the essential package of health services as a priority-setting instrument is less clear. Governments are increasingly under domestic and international pressure to use resources to protect their citizens from catastrophic health spending, which often comes from use of secondary and tertiary services.

1. INTRODUCTION

Priority setting is critical for governments that seek to promote equitable access to health care. An essential package of health services is a policy mechanism for a government to legally prioritize certain health services. An essential health services package comprises those health care services that a government is providing or is aspiring to provide to its citizens in an equitable manner (Wright and Holtz 2016). Another way that governments prioritize certain health services is through a health benefit plan. A health benefit plan is financed, at least partially, with public resources and provides financial protection to the covered population for an explicit list of services.[1]

The Health Finance and Governance (HFG) project is funded by the United States Agency for International Development (USAID) and helps to improve health in developing countries by expanding people's access to health care. HFG works with partner countries to increase domestic resources for health, manage those precious resources more effectively, and optimize purchasing decisions. HFG's work enhances the ability of USAID to assist countries in setting priorities and ensuring universal access to essential services.

An earlier HFG study of USAID's Ending Preventable Child and Maternal Death countries demonstrated that many governments have established an essential package of health services.[2] Most governments intend the public or private not-for-profit health facilities in the country to deliver this package of services. Meanwhile, many governments' strategies for pursuing universal health coverage include creating and scaling up health benefit plans.

Ethiopia, a country where both of these policy mechanisms exist, offers a good case for exploring how the two mechanisms help prioritize health services, and how the mechanisms relate to each other. The Government of Ethiopia published the *Essential Health Services Package for Ethiopia* (EHSP) in 2005 (FMOH 2005). The EHSP is more specific than those in many other countries. More recently, as part of its strategy to achieve universal health coverage, the government has been sponsoring two major health benefit plans. It has designed, piloted, and is currently scaling up community-based health insurance (CBHI) and it is preparing to implement social health insurance (SHI).

This case study seeks to address the following questions:

1. What is the origin, delivery, and governance of the EHSP, SHI, and CBHI in Ethiopia?
2. Are the policy objectives of the EHSP, SHI, and CBHI in Ethiopia aligned?

This report presents evidence to inform a response to the study questions. Evidence comes from HFG's multi-method study approach: a literature review and interviews with key informants, 15 experts on health policy and health system governance in Ethiopia who provided an important perspective on the origin, delivery, governance, and alignment of the EHSP and health benefit plans.

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[1] As defined by Giedion et al. (2014), health benefit plans: have a minimum set of explicit guarantees, are financed with public resources, and are linked to the needs or social preferences of the population to be covered.
[2] See final reports here: https://www.hfgproject.org/ephs-epcmd-country-snapshots-series/

The following sections of the report describe the background and case study findings based on the desk review and qualitative analysis of key informant interviews. The final section includes a discussion of lessons, perhaps applicable in other contexts, on seeking alignment between similar coexisting policy mechanisms that *de jure* or *de facto* prioritize certain health services. Study methods are described in the Annex.

2. BACKGROUND

With a population of 99.4 million people, Ethiopia is the second-most populous country in sub-Saharan Africa. With low-income country status, it has a per capita income lower than the regional average. The economy has grown over the past decade, accompanied by a reduction in poverty. The government aspires to reach lower middle-income status over the next decade. Over the past decades, Ethiopia made substantial reductions in child mortality but continues to face high maternal mortality (World Bank 2016).

Ethiopia is a Federal Democratic Republic with a centralized governance system. Health sector policies originate from the Federal Government via "directives" (a legal instrument) and then are implemented by regional and *woreda* (district) governments.

Health care is delivered through public and private health care facilities, but most private facilities are located in urban centers. For public facilities, the government pays the salaries of health workers and partially finances operating costs. Patients finance remaining operating costs through user fees, although some priority services are exempt. There is very little private health insurance in Ethiopia. Most people, including formal sector workers, do not participate in risk-pooling schemes.

To extend financial protection to large segments of the population, the Government of Ethiopia is implementing two risk-pooling schemes: CBHI and SHI. CBHI schemes are established by woreda governments and managed by community members. CBHI schemes collect premiums from households in the woreda, pool funds including subsidies, and then pay public health facilities to deliver services to enrolled members. The SHI scheme, which is in a final planning phase, will collect premiums from formal sector employees and employers through payroll taxes and then pay participating public and private health providers for delivering covered services to enrollees.

3. ESSENTIAL HEALTH SERVICES PACKAGE IN ETHIOPIA

This section presents experts' collective understanding of the EHSP in terms of its origin, delivery, and governance (such as its coordination, modifications, stewardship, and how it is maintained over time).

3.1 Origin

Experts traced the origins of the EHSP back more than a decade before the EHSP founding document was published in 2005. Before the term "essential health services package" was introduced, national health policy focused on developing standards for and improving access to primary health care. One respondent cited the 1993 National Health Policy[3] and the centralized planning process that took place in the Ethiopian health sector around 1997. At that time, which coincided with the Alma-Ata declaration and the global movement around increasing access to primary health care, the Government of Ethiopia developed policies for delivery and subsidization of primary health care nationwide. Other experts linked the origins of the EHSP to the notion of free health care championed in communist times.

The EHSP grew out of a widespread desire to provide basic, primary services in a way that reduced health inequities throughout the population. For example, services previously were concentrated in urban centers, and there was a desire to accelerate the expansion of health facilities to rural areas. Several experts alluded to egalitarian principles when describing the origins of the EHSP. One (Interviewee 5) commented on its constitutional basis, "*the idea of this essential health services packages was that, can the government commit, you know, some kind of affordable basic health services as a constitutional right to people?*" One expert shed light on the nature of the 1998 Health Financing Strategy (FMOH 1998) that preceded and set the stage for the EHSP:

"I was part of drafting what we call the first health finance strategy […] It clearly articulates that we need to have two kinds of services. One is what we call exempted health services which is to be financed either by the government or by partners that is going to be fully [subsidized] because of the public health interest." (Interviewee 2)

The strategy legislated a powerful role for the Federal Ministry of Health (FMOH) in subsidizing and providing primary health care services. As one expert (Interviewee 1) mentioned, "*these services they became free of charge since 1998 after the adoption of the health care financing legal framework in Ethiopia*." This was followed by a trial period in which incremental implementation of subsidized primary health care services was pursued in the Amhara and Oromia regions. In 2005, the FMOH published an EHSP listing those services considered essential by the government (mainly preventive and promotive services).

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[3] The foreword of the 2005 EHSP publication describes the EHSP as the government's effort to deliver on commitments made in the 1993 National Health Policy, which identified the need to develop and implement standards for delivering integrated primary health services at facilities and at the community level. The EHSP, it states, "*defines the core health and health related interventions to address major health problems and disease conditions of the country. These preventive, promotive, curative and rehabilitative interventions are considered to be the minimum that people can expect to receive through the various health delivery mechanisms and facilities within their reach*" (FMOH 2005).

Ethiopia's EHSP defines standards for service delivery in public health facilities, such as required human resources, infrastructure, and equipment. In essence, it identifies the health services prioritized by the government for the public sector delivery system – a system that has expanded greatly since the 1998 Health Financing Strategy. One interviewee (2) explained, "*in [Ethiopia] what we are trying to do is [… define] what minimal essential health services are going to be provided at [primary health centers]. So that was defined in 2005*."

Interviewees also suggested that the EHSP is closely linked with another government policy, "exempted services," which seems to *de facto* elevate certain services from the EHSP to a higher priority level by virtue of their being free for the patient. Public facilities collect user fees from patients at the point of care for all services except those that are exempted. One expert explained that the EHSP is the source document for defining the subset of exempted services. Over the years, the FMOH has issued directives to regional and woreda governments to designate new exempted services. According to one expert (Interviewee 1), these exempted services are part of, "*the normal vocabulary* and well known among the population since, "*health facilities* [...] *are required to post the list of the exempted health services in the compound.*"

To some experts, however, the line between the EHSP and exempted services was blurred. Some noted the confusion about which was which, and called for a clearer delineation of each category. According to one expert:

"Sometimes there might be some confusion and some mix up […] if we are not clear on these essential basic services and link it with basic health services and universal health coverage. We can't provide all services to all people." (Interviewee 6)

Interviewees agreed that the EHSP covers the entire population and prioritizes high-impact preventive services as well as curative services for communicable diseases. Interviewees also recognized that reproductive, maternal, neonatal, and child health interventions and services are actively promoted through the EHSP, particularly through the designation of these services as exempt from user fees. As one expert explained,

"Okay, everyone is entitled, but depending on the nature of service (you take maternity services, for example), you are targeting a segment of the population...like women in the reproductive age group [...]. If you take the exempted [services], they are available for everyone [...] and if you take the poor population who cannot afford [...] the user fees, the government – the original implementers – allocate some subsidy and [the poor can] access the services. So, the poor are also given attention [...], and those who can pay, can access the services, and the price has been subsidized […]. The package is basically for every citizen." (Interviewee 1)

3.2 Delivery

In defining the EHSP, several experts discussed mechanisms by which the EHSP is delivered, including facility- and community-based service delivery. Multiple interviewees linked it with Ethiopia's Heath Extension Program for community health workers. One expert implied that the government's effort to define the EHSP prompted the development of a community-level service delivery mechanism:

"Well, reflecting back, I guess it was carefully selected because it has prioritized all the country's inputs, problems. And the idea, also that, you know, this was like a very unique thing for Ethiopia. And if we could design this essential health services packages, then how do we make this accessible to the people? So, that kind of […] initiated the so-called extension program. And in a way, it's a driving force for innovations." (Interviewee 5)

Most interviewees also emphasized that provision of the EHSP was at the primary care level and was decentralized at woreda health facilities. As one expert (Interviewee 9) commented, there are currently 1,326 health centers, including five satellite posts and 54 functional hospitals that provide, "[...] *both inpatient, outpatient services, diagnostic services, and also the essential drug services and the laboratory services [...] to protect our community* [...]"

3.3 Governance

Given the linkages between the EHSP and exempted services, governance of the former is closely linked with the policymaking process of the latter. While the 2005 EHSP document has never been updated, the FMOH occasionally adds to the list of exempted services via directives to lower tiers of government. This process involves significant planning by and coordination among multiple administrative tiers. Health facilities must record and report the number of people they serve, as well as facility expenditures and cost recovery from user fees on non-exempted services. These data help the government in the ongoing process of determining which services to exempt from user fees, and how much that exemption would cost the government.

One expert reported that while the overall trend had been to expand the list of exempted services, the government is now considering reintroducing fees for some services: "*I have never heard of removing [services from the* EHSP*]. But we are now discussing for instance […] removing them from being free*" (Interviewee 2).

Several interviewees provided insight into the technical considerations that help guide the identification of essential services and their implementation. Despite competing health priorities, which create tension among stakeholders, many interviewees favored adjusting the EHSP to the changing epidemiological profile (e.g., increases in non-communicable diseases) of the population. As one expert (Interviewee 6) contended, "*It is usually very difficult because [...] program people want to add everything in the list, and the health system managers [...] want to balance the cost.*" Another (Interviewee 7) commented that this is what allows for the EHSP to be effective, "*The governance, it's dynamic by the way, and it is changing [...] tasks have shifted from the health centers to the health posts*." Similarly, another expert (Interviewee 8) argued, "[...] *but I believe it should be dynamic, it should be changing every time depending on the epidemiological changes."*

The approach the Government of Ethiopia has taken in developing other health policies might provide clues as to how it will manage modifying the EHSP when the process is initiated, as interviewees suggested will happen soon. Health policy development is largely conducted through technical consultations with experts and donors. The process of convening a technical working group in Ethiopia was described by a health policy expert who used to work in the FMOH:

"Usually they set up a technical working group, and then this technical working group will come up with a draft [policy] […] based on recommendations from local and international levels. Then they will […] call a wider audience representing different stakeholders. So, they will present for the audience and get feedback. Then they will work on the feedback and finalize." (Interviewee 8)

Interviewees considered the level of technical engagement and consensus building in Ethiopia to be good relative to other countries. Such engagement, they stated, lent legitimacy to the policymaking process. One finance expert (Interviewee 2) contrasted Ethiopia's approach with the process in other countries, which led to "shelf documents" that have little influence on the strategic direction of the health sector in the context of international donor priorities or interests. He claimed, "[...] *but in this country, it is completely different. Once it is approved, it becomes a budget and you cannot be allowed to change it."* The difference, he continued, was the strong role the government plays in the process:

"Because the government takes ownership of the strategies, if they don't agree, they will sort themselves out...if they bind those strategies, they will own it, and implement it. That is the difference. Why, for example, if you look at the health indicators...I have been working for the health sector for the last 30 years...from 1986 to around 2005 the progress was disappointing. But since 2005, because of this shift in ownership and leadership and taking it as a government policy and strategy and owning the strategy the whole shift of access, quality. […] So what you see is, once the strategies are adopted by the government, they are led to implement it [...] It has to part of that process first and this is the breakthrough for the changing health sector." (Interviewee 2)

4. HEALTH BENEFIT PLANS IN ETHIOPIA

This section presents interviewees' perspectives on the origin and governance of CBHI and SHI in Ethiopia.

4.1 Origin

In 2008, a process of high-level policy deliberations laid the foundation for the draft Health Insurance Strategy (FMOH 2010) that introduced two mechanisms for moving toward universal health coverage. The strategy involves scaling up woreda-level CBHI schemes to enroll the poor and those working outside the formal sector. SHI is expected to operate in parallel as a mandatory health insurance scheme for formal sector workers and their families. Through regulatory stewardship and implementation oversight by the FMOH and the Ethiopian Health Insurance Agency respectively, these parallel initiatives aim to rapidly increase financial coverage of health services and reduce out-of-pocket spending, while also increasing use of services.

Experts explained that CBHI and SHI drew from global experience with similar initiatives – in countries that have made significant strides toward universal health coverage, including Senegal, Rwanda, Mexico, Vietnam, and China – but were tailored to the Ethiopian context. One expert in particular provided a rationale behind CBHI schemes and the particular approach Ethiopia has adopted, based on the experience of countries such as Rwanda.

"[...] for low-income countries like Ethiopia, the only feasible way at the moment is CBHI, but when I say CBHI I am not talking about the failed CBHI voluntary schemes that are being managed and run around the world. You go to west Africa, [where] I was sent in 2001 to learn about CBHI and bring it to Ethiopia and I said forget it, that doesn't work because they only have very limited risk pooling, so the [number of] people that have benefited are small and [...] there are no subsidies from the government and also sharing so [...] the only way is the Rwanda way [...]. It is not about the size – that is where people get it wrong. People always get it wrong because they say Rwanda is the size of one woreda, but make that system work in each woreda and have different risk-pooling mechanisms and that is why, based on my recommendation, that this team is trying to create a risk-pooling mechanism at all levels. A risk-pooling mechanism at CBHI, mechanism at regional level, and possibly later on at national level [...] so it is not the size, it is the way it is designed what makes it different [...]. So basically what the government did was they established a team and then visited all countries from developing and developed countries and came up with an experience and then redesigned or designed the Ethiopian health insurance." (Interviewee 2)

4.2 Governance

The design of CBHI relied heavily on coordination mechanisms across the health sector. This included the formation of a National Coordination Unit, regional implementation units, and a regional steering committee, under the regional health bureaus. In addition, woreda health insurance committees were established in tandem with the lower-level *kebele* (village) health insurance committees. In this way, CBHI schemes could be adapted to the needs of local beneficiaries, thus empowering beneficiaries and allowing CBHI schemes to be continuously refined. The architecture of CBHI has been described elsewhere and is summarized in the following figure from Feleke et al. (2015).

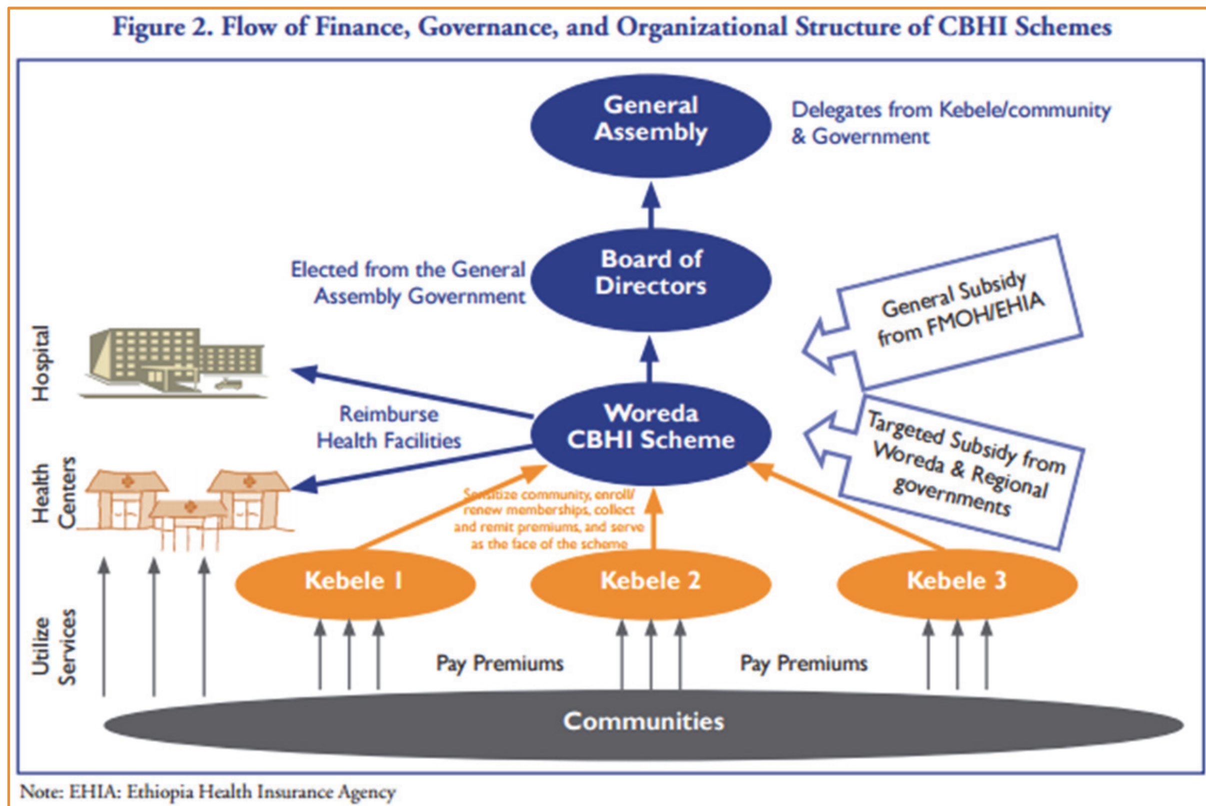

Figure 2. Flow of Finance, Governance, and Organizational Structure of CBHI Schemes

Note: EHIA: Ethiopia Health Insurance Agency

Source: Reproduced from Feleke et al. (2015)

The design of the CBHI benefit package is particularly important when considering alignment with the EHSP. CBHI covers all outpatient and inpatient services at the health center and nearby hospital level except false teeth, eye glasses, and cosmetic procedures. These services are excluded largely due to cost considerations. Enrollment in CBHI is done at the household level. The Federal Government subsidizes 25 percent of the premium, and indigents are eligible to receive a full subsidy of the remaining premium from woreda and regional government budgets.

As alluded to above, the benefit package for CBHI is largely defined using a negative list, stipulating which services are excluded, and not which services are covered. The decision to explicitly exclude services was questioned, as one expert (Interviewee 4) explained, "*The debate was if you are listing the benefit package negatively then it's very unpredictable. The cost is very unpredictable so first you have to start with explicitly positive and then expand the services based on your financial capacity.*" Because the services covered were so numerous, however, a negative list was deemed easier to implement and potential problematic design features could be addressed relatively easily.

5. ALIGNMENT OF POLICY OBJECTIVES BETWEEN EHSP, SHI, AND CBHI

Interviewees described the EHSP and the two health benefit plans as having different but complementary policy objectives. Interviewees describe the EHSP as a priority-setting mechanism, while CBHI and SHI are financial protection mechanisms. The EHSP explicitly identifies the health services prioritized by the government for the public sector delivery system. It also is a tool for defining standards for service delivery in public health facilities, such as required human resources, infrastructure, and equipment. According to one expert, "*Essentially what that essential package defines is what is a service that is going to be provided at health post level, which are exempted services."* In fact, according to this expert, what the EHSP does is much broader than simply defining service provision.

"[E]ssential health services packages [...] define the legal mechanisms which are the health posts, health centers, and primary hospitals. They define the human resources that are required to man these services. Based on the services, they define the necessary equipment and commodities that are required to provide this and based on that they have come up with what is called accelerated primary health expansion in Ethiopia." (Interviewee 2)

The degree of alignment between EHSP and the health benefits plans can be analyzed in terms of the alignment of service coverage, population coverage, and financial protection of these mechanisms. Service coverage of EHSP and CBHI appear to be aligned. One interviewee explained that CBHI provides financial protection for any essential service that is not already exempted. He explained, "*[EHSP includes] two kinds of services, some of them are curative and some are preventive and promotive. Some of them are part of CBHI and some of them are part of exempted services that are funded by the government*" (Interviewee 2). Service coverage of EHSP and SHI do not appear to be aligned because SHI will cover a wider array of services both at public and empaneled private health facilities. As one policymaker explained, "*SHI is more comprehensive than the EHSP. It includes the services that are being delivered at tertiary level, secondary level, and primary level*" (Interviewee 4).

Population coverage also appears to be aligned between EHSP and the health benefit plans. EHSP, by definition, covers the entire population. CBHI and SHI, when taken together as complementary health coverage initiatives, also aim to cover the entire population.

In terms of financial protection, the EHSP and the health benefit plans are more complementary than aligned. The EHSP is not a mechanism for providing financial protection to Ethiopians (although it did provide a starting point for the government to designate a subset of those services exempt from user fees). CBHI and SHI, on the other hand, represent the government's efforts to reduce out-of-pocket spending for health care. The rationale behind introducing health insurance in Ethiopia is to increase utilization of services by reducing financial barriers for curative health services. As one expert (Interviewee 2) explained, "*the whole issue of insurance here in Ethiopia, particularly CBHI, is to reduce out-of-pocket spending by the community and reduce financial barriers*."

One expert explained the challenges of implementing CBHI in an environment where some services already receive enhanced financial protection.

"I am not sure how well they are aligned when people are communicating. […] We have to be really careful how we are communicating. This essential health services package, people might take it as basic care, like the concept of primary care [...]. My understanding is that these are the services that the government commits maybe to the funding of the government [...]. If these two are identical, […] people joining the insurance might say: 'So, what is different? Why should I pay when the government has committed by essential health services package to provide the services for free?' So, […] the additional benefits have to be clearly communicated." (Interviewee 5)

6. CONCLUSION

This case study documents a government's health services priority-setting process, and experts' perceptions on whether and how various health systems initiatives align to promote population access to priority health services. It presents a unique and noteworthy result: a collective understanding of the origin, purpose, and governance of a country's essential package of health services and its two publicly sponsored health benefit plans, and how the different mechanisms align.

The study suggests that health policymakers and experts generally agreed that the essential package of health services is an important policy tool and should be aligned with other health coverage initiatives like Ethiopia's CBHI and SHI programs. However, the static nature of Ethiopia's EHSP presents challenges for the stewards of the country's health system. The EHSP has not been formally updated since it was published in 2005, although several experts pointed out that the government has plans to update it in the near future. At the same time, the government defines and updates what it considers to be priority services in other, perhaps more agile and direct, methods (i.e., government directives, health insurance programs, etc.). Identifying how to align the different policies/initiatives is more challenging. Given this limited clarity, policymakers and the international community may benefit from further dialogue about the best applications of and alignment between an essential package of health services and health benefit plans within a country.

The Ethiopian experience suggests that the value of essential packages of health services may change as health systems evolve. All low-income countries face severe constraints in financing their health systems. This makes priority setting all the more important. Because the essential package of health services is a basic priority-setting instrument, its value is critical in the absence of more sophisticated financing arrangements, such as health benefit plans. Ethiopia has been experimenting with health benefit plans, such as CBHI, and is looking ahead to transforming health financing through SHI. It is not surprising then that the experts interviewed for this case study spend little time looking back to a more basic priority-setting instrument. We propose that future research could test this idea by comparing the utility of essential packages of health services among countries at different stages of development in their health financing systems. This is not to diminish the important role that essential packages of health services play at early stages of health system development, but rather to better understand their role as countries develop more robust forms of risk pooling.

ANNEX: STUDY METHODS

This study used case study methods (Yin 1994) to answer a set of research questions in a specific context. The study involved several steps, including defining research questions, designing a research protocol, selecting the case study country, collecting data, and analyzing data.

Design

Defining research questions

Upon completion of an earlier study performed by HFG and funded by USAID, several topics were identified for further investigation. HFG and USAID jointly developed the two main research questions.

Designing a research protocol

The research protocol was designed to address the study questions. HFG researchers determined that the questions could be best addressed using a qualitative case study design. HFG designed the case study protocol using well-established qualitative research methods (Yin 1994). HFG then designed an interview guide to enable researchers to collect qualitative information related to the study questions through key informant interviews.

After finalizing the study protocol, the HFG researchers submitted the study design and data collection instruments to Abt's Institutional Review Board for review. The study was found exempt from full review.

Selecting the case study country

Researchers developed and applied three selection criteria to inform the selection of the case study country:

1. The country is a USAID priority Ending Preventable Child and Maternal Death country
2. The country's government has defined an essential package of health services
3. The country's government is implementing one or more major health benefit plans with an explicit list of covered services

HFG and USAID selected Ethiopia as the case study country because it fit all three criteria and the panel believed it would provide a compelling story. In 2005, the government had defined and published a clear and detailed essential package of health services called the *Essential Health Services Package for Ethiopia*. The current administration is scaling up CBHI for the informal sector and the poor (89 percent of the population) and is in late-stage preparations to launch an ambitious SHI scheme for the formal sector (11 percent of the population).

Implementation

Desk review

HFG researchers collected contextual information on the EHSP, CBHI, and the SHI scheme through a desk review. Researchers identified formal and gray literature through internet and database searches using Google, Google Scholar, and the PubMed database, and through identification of unpublished documents through HFG project staff with expertise in Ethiopian health policy. HFG researchers used the results of the desk review to tailor the semi-structured interview guide to the Ethiopian context and to create an initial list of potential interviewees.

Recruitment of interviewees

HFG researchers finalized a list of potential interviewees based on the desk review and in consultation with HFG project staff familiar with health financing and health policy in Ethiopia. HFG compiled a list of names and contact information of potential key informants. The informants included representatives of government agencies and development partners who were familiar with the history and policies surrounding the EHSP, CBHI, the SHI scheme, or any combination. Between May 30 and June 10, 2016, study participants were purposively recruited by telephone or email by the Chief of Party for the HFG project in Addis Ababa, Ethiopia.

Qualitative data collection

Two Washington, DC-based HFG researchers with complementary qualifications traveled to Addis Ababa, Ethiopia, to conduct in-depth semi-structured interviews. One researcher had expertise in health financing and the other had expertise in qualitative health policy research.

HFG researchers conducted interviews using the interview guide over the course of five business days. The researchers did in-person interviews with 15 senior policymakers and technical experts at their places of work. They conducted the first five interviews jointly to ensure consistency in future interviews conducted individually. The researchers followed the semi-structured interview guide for the interviews, but adjusted the interview questions depending upon the respondent and his/her knowledge of the EHSP. All interviews were conducted in English. Before each interview, HFG obtained verbal consent from the interviewee to conduct and record the interview. No interviewees declined to participate or refused to be recorded. HFG researchers also completed detailed field notes within 24 hours after each interview. All interviews were recorded and transcribed verbatim by a professional transcription service for thematic content analysis.

Coding and analysis

HFG imported the interview notes into NVivo 11, a qualitative data analysis software package, for coding and analysis. A codebook with approximately 22 analytical codes was developed to organize and clarify certain features of and degree of alignment between the EHSP, CBHI, and SHI. The codebook was slightly refined after coding a small sample of interview notes from several cases. To accommodate the emergence of new themes from the interview data, the codebook included inductive codes that were based on the understandings of interview participants. We applied this common codebook for the purposes of reliability, quality control, and comparison across interview respondents and eventually across case and country contexts.

Once coding was complete, HFG conducted iterative, exploratory analysis in NVivo 11 using text analysis techniques (e.g., identifying repetition, similarities and differences, word frequency, word co-occurrence, etc.) to explore themes, patterns, outliers, and trends, and conflicts between and among data sources. We reviewed secondary data captured through the desk review. We analyzed the findings from the literature and document reviews in conjunction with analysis of the primary data and field notes.

HFG ensured the reliability and validity (external and internal) of the qualitative research in several ways. First, the researchers reordered the questions from the semi-structured interview guide after the first interview to improve the interview flow. Second, they paired subject matter experts with HFG researchers in the first five interviews to ensure consistency and adequate reflection on the precision of the interview guide based on the research goals. Third, they triangulated the findings through the use of multiple data sources to arrive at themes and conclusions. Fourth, they transparently reflected on their position as researchers and their role in data collection and analysis, which were included in the interview notes. Fifth, they used consistent data documentation procedures and structured, systematic analysis techniques using qualitative analysis software (NVivo 11) to ensure reliability and quality control. Finally, they conducted member-checking by sharing the findings with interview participants. They then finalized the case narratives based on this feedback.

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