Determinant Criteria for Designing Health Benefit Package in Selected Countries

Mohammad Javad Kabir[1], SoudabehVatankhah[2], Bahram Delgoshaei[3], Hamid Ravaghei[4], Nahid Jafari[5], Alireza Heidari[6], Naser Behnampour[7], Mohammad Reza Honarvar[8], Korosh Etemad[9]

[1] PhD Candidate in health services management, School of Health Management, Tehran University of medical Sciences, lecturer of Community medicine, Department,Golestan University of Medical Sciences, Gorgan, Iran.
[2] Associate professor, PhD, Health Service Management, School of Health Management, Tehran University of medical Sciences,(Corresponding Author).
vatankhah_s@yahoo.com
[3] Associate Professor, Health Services Administration, School of Health Management Tehran University of Medical Sciences
[4] Assistant Professor, PhD, Health Policy, School of Health Management, Tehran University of medical Sciences
[5] Assistant Professor, Specialist of Community Medicine, Health Management and Social Development Research Center, School of medicine, Golestan University of Medical Sciences, Gorgan, Iran
[6] PhD, Candidate in Health Policy ,Health Management and Social Development Research Center, Golestan University of Medical Sciences, Gorgan, Iran.
[7] PhD, Candidate in Biostatistics, Tarbiat Modares university, Tehran, Iran, lecturer of Public health , Department, Golestan University of Medical Sciences, Gorgan, Iran
[8] PhD Candidate in nutrition, School of health, Tehran University of medical Sciences, MD, Mph Health Management and Social Development Research Center, Golestan University of Medical Sciences, Gorgan, Iran.
[9] PhD Epidemiology, Health Management and Social Development Research Center, Golestan University of Medical Sciences, Gorgan, Iran.

Abstract: Health benefit package described as primary health interventions that provided with government using general funds for all regardless their financial ability. This study was aimed at determine appropriate pattern for Iran using comparative survey of Health benefit package in various countries. A review exploration was done, scholars was selected population of both developed and developing countries, required information was also extracted by articles, searches and reports of reliable sources and date were analyzed by SPSS, in brief. The vast majority frequencies was respectively allocated to accessibility (40.7%), cost- effectiveness (29.6%), prioritize, efficacy and cost (22.2%). most countries located in WHO African region were selected cost-effectiveness and accessibility, WHO southeast Asia region were selected, coverage, prioritize, efficacy and quality and finally most WHO Europeans region were elected effectiveness and services costs for including services in Health benefit package . According to most Health benefit package designer emphasis on criteria including accessibility and cost-effectiveness, to design Health benefit package for Iran, these criteria must be noticed.
[Mohammad Javad Kabir, SoudabehVatankhah, Bahram Delgoshaei, Hamid Ravaghei, Nahid Jafari, Alireza Heidari, Naser Behnampour, Mohammad Reza Honarvar, Korosh Etemad. **Determinant Criteria for Designing Health Benefit Package in Selected Countries.** *Life Sci J* 2013;10(3):1392-1403] (ISSN: 1097-8135).
http://www.lifesciencesite.com. 210

Key words: comparative survey, primary level of health services, primary health care, Health benefit package, criterion.

Introduction:

The need for fundamental change in health care strategy was the fact that the World Health Organization achieved using collecting different documents of various countries and finally in 1977, in the thirtieth session of the World Health Organization, strategy of health for all by the year 2000 was adopted. The key to achieve this level of health was recognized as primary health care that in each country must be determined in relevant with community development level but have to include 8 primary services at least (8). Primary care with universal access and social protection is both provider and promoter of people health (2). None of health system cannot provided mentioned groups with health interventions because of governmental limited budgets, therefore; they are forced to use both services and different source allocation. Improve the benefit and use of the services can be possible through decrease costs that are realizable by using of multiple interventions as a health service package. Also, in the situation that required inputs for doing special interventions leads to high costs, intervention integration through a comprehensive overview make it possible to required outputs achieved using rationalize costs.

Service package causes:

- All required inputs for promotion and forming a specific intervention is defined.
- Coordination between needed technical, executive and educational sources is fulfilled.
- Interventions and prioritized performances should not be neglected.
- Make planning and investment more easier in determining of necessary infrastructures, personnel training as well as input providing such as drugs and equipment, besides; considering prevention, many of costs and medical practices can be eliminated(3).

As aforementioned, delivering primary health services through Health benefit packageis necessary to be revised. Improving people health, re-design and logical planning of health care system, making the personal responsibility, decrease general costs of health care, having innovation, forming community safety and social support, available, organizational values reporting and evidenced based are the goal of designing necessary services package(4).

Health benefit packageis consisted of vital and prioritized services that have mentioned characteristics:

- It is a limited complex of all health care interventions that for its making all political, cultural and socio-economical contexts must be considered.
- A prioritizing process used for selecting intervention to achieve social and technical goals.
- Interventions within the package are not independent of each other and many of them have been specifically chosen to complete and reinforce each other (5-17).

According tothe World Development Report published by the World Bankin 1993, the Health benefit package includes:

- Health benefit package define as medical and health primary interventions that provided by general funds for all regardless of government afford.
- Poor people access to services from public funds, selecting health services based on maximum obtained profit using available sources, making more efficacy and higher quality of World Bank recommended principle.

Profits of health benefit package include:

Forming relation between prevention and treatment, identify all required inputs, acquisition of more outputs than inputs, Coordinating resources, lead services in right direction, appropriate criteria for coverage of health services, basis for used insurance plans, assurance peace, security and integrity(16.17).

Multiple centers of decision making to provide resources of Iran for making health benefit package leaded to many problems. Issues such as health trusteeship fading, inadequate proper tools for cost management targeted in health sector, reduce the effectiveness of services, limited health resources, insufficient appropriate evidence for effective interventions in the healthcare system, Inadequacy of appropriate policies to make a coordination between insurance organizations and the Ministry of Health in developing new service for health benefit package, growing inequity gap of gained benefits by various classes of society in terms of health benefit package, The need for reasonable scientific pattern for designing health benefit package at the primary level is obvious and can also resulted in more apt allocating and management of existed health resources and attention to both needs and priorities that is a key criterion in making decision of health policy makers.

Since, both implemented approach in different countries has not been successful, and it is not even possible to use a universal and regional pattern for revising health system, therefore; it necessitated that consider variables comprising history, capacities, values and culture of society and act based on adequate information and appropriate tools(18-19). According to aforementioned issues, Iran health system is forced to use native and universal experience for designing health benefit package. Thus, the current survey is explored health benefit package comparatively in different countries to determine a fitted pattern for Iran.

Material and methods:

This study is description- comparative that implemented using search authentic articles and theses regarding health benefit package and results were analyzed for selecting eligible criteria of health benefit package. These studies were done by using of sources including Google scholar, PubMed, Science Direct and Scopus that indexed many of published journals and studies. In search process, published studies in 1975 to 2012 were perused. Besides, Persian published studies were also analyzed by searching scientific sources such as Magiran, Iran medex and SID. In this survey, unrelated studies were not noticed. Observed studies were both published quantitative and qualitative exploration in Persian and English. Used keywords were Benefit package, health benefit package, Basic package, Primary Health Care ،priority setting, Essential Benefit Package, Criteria, Model, design and modeling for essential health benefit package.

Above keywords were searched in mentioned sources as advanced and using OR-AND operators. Then, abstracts were explored and related issues were consequently selected and unrelated ones were discarded. Types of searched articles were Original Article،Short Communication،Review Article, moreover; editorial articles were not considered and full text articles were entered study as well. 30 health benefit packages were extracted of studies. Data were analyzed using SPSS (18.ver) and descriptive statistical methods.

Results:

Surveyed packages were included:

Liberia (20), Tanzania (21), siraleon(22), china(23),Sudan(24), Iraq(25), Poland(26), Lesotho(27), Bangladesh(28), Nigeria(29), Bosnia and Herzegovina(30), Malawi(31), Chile (32), Kenya(33), Kamboj(34), Mexico(35), Denmark, France, Germany, Hungary, Italy, Netherland, Spain and England(36), Afghanistan(37), Uganda(38), Argon province of United States(5), South Africa(39), Ethiopia(40) and United States Medical Institution(41).

History of criteria for selecting a service for health benefit package among 30 countries covered by WHO are:

In WHO African region about 11 health benefit package, WHO American region around 2 package, WHO Southeast Asian 3 package, WHO European region 10 package, WHO East Mediterranean 2 package and finally in WHO west ocean 2 health benefit package.

In WHO African region because services to be involved in package, 55.6%, 63.6%, 45.5% and 27.3% of packages were selected criteria including cost-effectiveness, accessibility, availability and propriety, prioritize, equity and quality, respectively.

In WHO Southeast Asian region, eligible criteria for entering the package were: 66.7% and 33.3% of packages were selected criteria such as accessibility and prioritize, efficacy, quality, being responsible to people needs and coverage, respectively.

In WHO European region, 40% and 20% of packages were selected cost-effectiveness, services-cost and need and safety, respectively.

In WHO East Mediterranean, 100% of package were voted to criteria including accessibility and 50% were selected criteria such as availability, prioritize, acceptable, effectiveness, people satisfaction, efficacy and quality.

In WHO West Ocean, 50% of packages were selected criteria comprising cost-effectiveness, being accountable to society needs, precise definition for service, being evidence based, burden diseases, being applicable and needs.

In WHO American region, 100% of packages were selected criteria such as financial supply and availability.

The vast majority of countries located in WHO African region were opted criteria including cost-effectiveness and accessibility, WHO Southeast Asian region were selected criteria such as coverage, prioritize, efficacy and quality, WHO European region were elected criteria comprising effectiveness and costs of services.

Access criterion was existed in the most WHO regions (Africa, Southeast Asia, Europe and United States). Moreover; cost-effectiveness criterion was also observed as another factor in the most WHO regions (Africa, west of pacific, Europe and United States). Table 3 shows criteria of health services package of selected countries based on WHO regions.

GDP was less than 1000 Dollar in 37% of countries including Liberia, Malawi, Sierra Leon, Uganda, Afghanistan, Tanzania, Bangladesh, Kenya and Ethiopia. GDP was also 1000 to 15000 Dollars in29.6% of countries such as Nigeria, Cambodia, Iraq, Bosnia and Herzegovina, Mexico, Chile, Poland, Hungary and South Africa, and it was finally more than 15000 Dollar in 33%of countries including China, Spain, Italy, England, Germany, France, Netherland, United States (Argon Province) and Denmark. Table 5. Represents criteria of health services package of aforementioned countries based on GDP.

According to health allocation of GDP, mentioned allocation was less than 6% in countries including Bangladesh, Ethiopia, Iraq, China, Kenya, Tanzania, Nigeria, Cambodia and Mexico. It was 6 to 9% in countries comprising Sudan, South Africa, Poland, Hungary, Afghanistan, Chile, Lesotho, Uganda, Italy, England and Spain and finally in countries such as Malawi, Netherland, Denmark, Bosnia and Herzegovina, Germany, France, Sierra Leon, Liberia and United States (Argon Province) was more than 9%. Table 6 presents criteria of health service package in discussed countries based on health allocation of GDP.

Life expectancy was less than 60 years in countries including Liberia, Uganda, Afghanistan, Tanzania, Sierra Leon, Sudan, Iraq, Lesotho, Nigeria, Malawi, Kenya, Cambodia and South Africa, 60 to 70 years in Bangladesh, and it was also 70-80 years in countries comprising United States(Argon Province, Medical Institution), China, Poland, Bosnia and Herzegovina, Chile, Mexico, Denmark, Germany, Hungary and Netherland. Besides life expectancy was more than 80 years in countries including France, Italy, Spain and England. Table 7

describes criteria of health service package of selected countries based on life expectancy.

Discussion and conclusion:

Providing primary health care services as health benefit package can result in benefits gained by most population in terms of health services. According to gained results of current study, access criterion had most frequency of health benefit package. In some cases, access means that do services deliver in special regions or not. In fact, it means service is existed physically that can be measured using existed inputs delivering (bed, physicians or nurses) for population compared to total.

Another definition that is conceptually close to aforementioned compliment is effectiveness; it means that how easy is care received by people?

Many of people specially living in developing countries have not access to health services and technologies even basic kind of that such as vital drugs. Cost of health services and technologies is one of the most critical access barriers. Personal payment of health costs affected access poor groups, severely. Poor people do not have enough money to buy health care. In terms of access to health services and technologies, there are many difficulties including costs of services, problems of services geographical distribution, lack of political commitments to improve health status that in many cases, overcoming the problems seems likely impossible (43). Governments are looking for the fact that selecting health services by people is an informed election and required services will be achieved by spending minimum costs and distance. In some society that health services is known as one of the essential variables of living conditions improvement, access to services is one the critical traits of health service delivering system and it is also one of equity criteria. It seems that attention of health benefit package designer to access as the first priority of designing health benefit package has caused by importance of health criteria promotion, increase equity status, improvement of people benefits of health services and their satisfaction, in brief.

According to results of current study, another criterion that had the most frequency of health benefit package was cost-effectiveness. Cost-effectiveness is one of the most effective factors of investment for achieving a planned special goal. Cost- effectiveness measurement is related to both cost evaluation and project cost-effectiveness evaluation (44).

Cost- effectiveness evaluation is a scientific method that assist decision maker to select a project from various plans which designed with different strategies to reach definite goal in such a way that has most effectiveness whereas has fixed cost, moreover; by considering fixed level of cost-effectiveness result in minimum possible cost(45). Cost- effectiveness evaluation is a method to facilitate decision- making process. This analysis is a way that makes distinguish program defaults possible and it also provides better program planning as well. Each cost- effectiveness exploration is included outputs evaluation (effectiveness) and process that must be used for achieving determined goals (costs) using different methods. Cost- effectiveness must be surveyed possibly when for reaching a goal is existed more than a way (46). It seems that attention of health benefit package designer to cost- effectiveness criterion is due to importance of health interventions current and capital costs with cost-effectiveness interventions that in the most cases, effectiveness criterion is catastrophic burden diseases in mentioned countries. According to results, most of countries located in WHO Africa region, WHO Southeast Asia region, and WHO Europe region to services entered the package reported criteria including cost-effectiveness and access, coverage and prioritize, effectiveness and services costs, respectively.

Factors such as long distance between cities and villages, inappropriate economic status of most people and low development of WHO Africa region are seems cause of more selection of access criteria about health benefit package in this area. On the other hand, low income of region countries lack of sources and plentiful primary health needs of region has necessitate policy makers to use cost-effectiveness criterion regarding health implemented interventions.

It seems that span of region, climate and geographical situation, highly populated area justify the need of coverage criterion of health benefit package in WHO Southeast Asia.

According to results of investigated and mentioned countries, it can be inferred that great health allocation of GDP, people high expectation of government about better quality services and finally people high expectation about using advanced and expensive medical equipment are the cause of selecting cost criterion of health benefit package in WHO Southeast region.

Considering the results of current survey, most criteria in both countries with high Human Development Index and countries with low Human Development Index were common. As HDI has been implemented for estimating national and regional and multilateral welfare, moreover; it also intended to estimates mean access of a country in three critical aspect of Human Index (long life accompanied by health, knowledge, and life efficiency standard). This criterion is the most important population characteristics of societies that pay attention to life condition and primary rights and is also one of

evaluation criteria of millennium development goals. Of course; this criterion can be vital for determining society needs about health services and also their usage method of health benefit package as a key variable, this means that people determine their needs consciously and ask governments, besides; governments are more accountable in countries that have better HDI. Health benefit package providers seem to have shown little interest in this important criterion for designing package. However; further exploration in this regard are recommended.

Although, health allocation of GDP of each country represent the sub- economic compared to other economic part in the same country and cannot be used as a criterion for comparing volume of this part in different country across the world (45), but the results show that countries that have less health allocation of GDP used different criteria for designing health benefit package compared to other countries in such a way that criteria including services accessibility for at risk groups, prioritize main health problems, services coverage for vulnerable population and having popular prestige for interventions observed in services package of countries having low health allocation of GDP. However; criteria such as guarantee civil rights, increase personal accountability and decentralization observed in services package of countries having great health allocation of GDP. This difference may cause by different people needs and expectations of both countries. Performance of services delivering system of developed countries means that whatever the sources of GDP allocated to health is more targeted, therefore; more efficiency and effectiveness would be achieved. This issue is obvious in developed countries; these cases by designing proper pattern of health benefit package in a relatively long period of time have always tried to accentuate on their society minimum benefits of mentioned package.

Life expectancy is one of remarkable effects of appropriate use of health benefit package. Results derived of searched countries showed that every country with better HDI and higher health allocation of GDP made need based service package with maximum efficacy and effectiveness, and in this countries, life expectancy as a final output is obviously significant, This shows that life expectancy made by factors such as evidence- based decision making, proper accountability and people informed participation in health systems in different countries.

Studied criteria of package showed that life expectancy has a little effect on selecting criteria in such a way that both developed and developing countries behave in the same way.

Acknowledgement:
This study was part of a PhD dissertation
Supported by Tehran University of Medical Sciences (Grant No.: TUMS/SHMIS-1390/668)

INDEX

Table 1. Frequency of criteria of health benefit package in surveyed countries.

Gained criteria	Health portion of GDP (٪)	Life expectancy	GDP	Human Development Index (2011)	WHO regio n	Country nam e
➢ Cost-effectiveness ➢ Merger ➢ Evidence based services coverage ➢ Adequate financial supply of services ➢ Innovation in package designing ➢ Increase being responsible in personnel ➢ Availability for people ➢ Access to services	15.2	78.2	47284	0.910	AMRO	Argon Province of United States
➢ Public access ➢ Decentralization in services delivering ➢ Proper management ➢ Adequate financial supply of services	11.9	45.7	226	0.329	AFRO	Liberia
➢ Cost- effectiveness ➢ Access to services	8.4	51.5	501	0.446	AFRO	Uganda

➢ Access to services	7.4	43.8	517	0.389	EMRO	Afghanistan
➢ Prioritize health main problems ➢ Cost- effectiveness ➢ Attention to prevention and treatment concurrently ➢ Quality improvement ➢ Being responsible to all people needs ➢ Having suitable general prestige ➢ Coordination of mutual interventions ➢ Maintenance of effective interventions	4.5	52.5	548	0.456	AFRO	Tanzania
➢ Prioritize health problems ➢ Cost- effectiveness ➢ Equal access to services for rural and urban population	13.3	42.6	326	0.336	AFRO	Sierra Leon
➢ High services coverage for all population	3.4	79.3	18458	0.687	SEARO	China
➢ Cost- effectiveness ➢ Availability ➢ Accessibility ➢ Prioritize health problems that form burden diseases	6.9	58.6	1705	0.408	AFRO	Sudan
➢ Prioritize health problems ➢ Services coverage for vulnerable population ➢ Quality services promotion ➢ Improve access physically and financially ➢ Increase devotional efficacy ➢ Increase services effectiveness ➢ Satisfy services customers ➢ Being available financially ➢ Being acceptable socially and politically	3.3	59.5	2564	0.573	EMRO	Iraq
➢ People equal access to services ➢ Prioritize at risk groups(children, pregnant women, disables and adults)	**7**	75.6	12300	0.813	EURO	Poland
➢ Cost- effectiveness ➢ Availability ➢ Accessibility	7.6	42.6	837	0.450	AFRO	Lesotho
➢ Prioritize services ➢ Availability of services for vulnerable groups ➢ Increase efficacy ➢ Responsiveness	3.3	46.1	638	0.500	SEARO	Bangladesh
Comprehensiveness of services	5.2	46.2	1389	0.456	AFRO	Nigeria
➢ Solidarity ➢ Equality ➢ Guarantee civil rights	10.3	74.6	4319	0.751	EURO	Bosnia and Herzegovina
➢ Services quality ➢ Availability of services	9.1	48.3	322	0.400	AFRO	Malawi

➢ Surveillance of demands and all needs ➢ Determine services exactly at primary and secondary level ➢ Cost of executing services ➢ Evidence- based ➢ Responsiveness people expectation	7.5	78.6	11828	0.805	WPRO	Chile
➢ Availability ➢ Equity-based ➢ Effectiveness	4.2	54.1	809	0.509	AFRO	Kenya
➢ Services quality ➢ Poor people access to services	5.7	59.7	814	0.523	SEARO	Cambodia
➢ Burden disease ➢ Cost- effectiveness of intervention ➢ Inexpensive services ➢ Applicable ➢ Considering catastrophic costs of services	5.9	76.2	9566	0.770	WPRO	Mexico
➢ Need ➢ Budget for services	9.9	78.3	56147	0.895	EURO	Denmark
➢ Effectiveness of services ➢ Safety of services	11.2	80.7	41019	0.884	EURO	France
➢ Efficiency ➢ Be suitable ➢ Cost- effectiveness of services	10.5	79.4	40631	0.905	ERUO	Germany
➢ Costs of services ➢ Effectiveness of services	7.2	73.3	12879	0.816	EURO	Hungary
➢ Costs of services ➢ Effectiveness of services	8.7	82	34059	0.874	EURO	Italy
➢ Costs of services ➢ Effectiveness of services	9.9	79.8	47172	0.910	EURO	Netherland
➢ Safety of services ➢ Effectiveness of services ➢ Efficacy of services	9	80.9	30639	0.874	EURO	Spain
➢ Costs of services ➢ Funds of services	8.7	80.1	36120	0.863	EURO	England
➢ Equity ➢ Quality ➢ Availability ➢ accessibility ➢ Burden diseases	8.5	48.8	10278	0.619	AFRO	South Africa
➢ Cost- effectiveness ➢ Availability ➢ Equity ➢ Necessity ➢ Capacity ➢ Availability	4.3	54.3	934	0.363	AFRO	Ethiopia
➢ Cost ➢ Most Importance ➢ Financial supply ➢ Better care ➢ Availability ➢ Insurance coverage ➢ Supporting vulnerable people	15.2	78.2	47284	0.910	AMRO	United states Medical Institution

Table 2. Frequency of criteria derived from health benefit package of investigated countries.

Criterion	Frequency	Percent
Cost effectiveness	9	30
Merger	1	3.3
Coverage	3	10
financial supply	3	10
Innovation in package designing	1	3.3
Services availability	8	26.7
access	13	43.3
Decentralization	1	3.3
Being suitable	4	13.3
Prioritize	6	20
Attention to prevention and treatment concurrently	1	3.3
Accountable to society needs	3	10
Having popular prestige	1	3.3
Preservation of effective interventions	1	3.3
Acceptability	1	3.3
Efficacy	3	10
Effectiveness	6	20
People satisfaction	1	3.3
Comprehensiveness of services	1	3.3
Merger	1	3.3
Equality	1	3.3
Considering of civil rights	1	3.3
Cost of services	7	23.3
Accurate definition of services	1	3.3
Document-based	1	3.3
Equity	3	10
Burden diseases	2	6.7
Applicable	1	3.3
Services funds	2	6.7
Need	3	10
Safety	2	6.7
Efficiency	1	3.3
Efficacy	3	10
Quality	5	16.7
Necessity	1	3.3
Capacity	1	3.3
Serviced by insurance	1	3.3
Supporting of most at risk individuals	1	3.3
Better care	1	3.3
Most importance	1	3.3
Personal accountability	1	3.3

Table 3. Criteria of health services package of selected countries based on WHO regions

Region	Criterion
Africa	Cost-effectiveness, financial supply, availability ،accessibility ،decentralization ,appropriateness, prioritize،attention to prevention and treatment, being accountable to society needs ،having popular prestige, preservation of effective interventions, effectiveness ،comprehensiveness, equity،quality, necessity, capacity and burden diseases
Southeast Asia	coverage, access, prioritize, accountability of society needs, efficacy, quality
Europe	Cost-effectiveness, access, being appropriate, prioritize, efficacy, effectiveness, solidarity, equality, considering civil rights and costs of services
United States	Cost-effectiveness, merger, coverage, financial supply, innovation in package designing, availability, accessibility, insurance coverage, supporting at risk individuals, better care and most importance
Eastern Mediterranean	Coverage, availability, prioritize, acceptable, efficacy, effectiveness, people satisfaction, quality
West of pacific	Cost-effectiveness, being accountable to society needs, clear definition of services, document-based, burden diseases, applicable and need

Table 4. Criteria of health service package based on Human Development Index.

Human Development Index	Frequency	Criterion
>0.635	13	Cost effectiveness, coverage, financial supply, availability, accessibility, decentralization, being suitable, prioritize, attention to prevention and treatment, being accountable to needs, popular prestige, preservation of effective interventions, acceptable, efficacy, effectiveness, people satisfaction, comprehensiveness, burden diseases, equity, necessity and capacity
0.636-0.745	2	Coverage, solidarity, equality, guarantee civil rights
0.741-0.897	9	Cost-effectiveness, access, prioritize, being accountable to needs, efficacy, effectiveness, costs of services, accurate definition of services, evidence-based, burden diseases, applicable, financial supply, need, safety and efficacy
>0.898	3	Cost- effectiveness, merger, coverage, financial supply, innovation, availability, access, appropriateness, effectiveness, costs of services, efficiency, most importance, supporting at risk individuals, better care and serviced by insurance

Table 5. Criteria of health services package of target countries based on GDP.

GDP	Frequency	Percent	Criterion
<1000	10	37	Quality, access, decentralization, appropriate management, financial supply, cost-effectiveness, prioritize main health problem, attention to prevention and treatment concurrently, quality improvement, being accountable to all population needs, popular prestige, coordinating of mutual interventions, preservation of effective intervention, necessity and capacity.
1000-15000	8	29.6	Comprehensiveness of services, quality, accessibility, prioritize health problems, service coverage of vulnerable groups, services quality improvement, physical and economical accessibility improvement, allocation efficiency, effectiveness, satisfy service customer, availability, acceptability, solidarity, equality, guarantee civil rights, cheapness of services, applicable, considering service catastrophic costs, surveillance of demands and all needs, determine services at primary and secondly level accurately, cost of service implementation, evidence- based, being accountable to people expectation, prioritize at risk groups(children, pregnant women, disable individuals and adults), comprehensiveness of services and burden diseases.
>15000	9	33.3	Coverage, service safety, effectiveness, efficacy, costs, effectiveness, fund, efficiency, appropriateness, service cost- effectiveness, cost-effectiveness, merger, evidence-based service coverage, most importance, supporting at risk groups, better care, insurance coverage, financial supply, innovation in package design, increase personal accountability, availability, access to services and need.

Table 6. Presents criteria of health service package in discussed countries based on health allocation of GDP.

Health allocation of GDP	Frequency	Percent	Criterion
>6%	10	37	Prioritize services, accessibility of services for at risk groups, increase efficacy, accountability, service coverage for vulnerable groups, service quality improvement, service effectiveness, satisfy customers of services, availability, acceptability, service coverage, equity based, effectiveness, prioritizing main health problems, cost-effectiveness, attention to prevention and treatment concurrently, being accountable of society needs, having praiseworthy prestige, coordinating mutual interventions, preservation of effective interventions, service comprehensiveness, service cheapness, applicable, considering service catastrophic payment, burden diseases, capacity and necessity.
6-9%	8	29.6	Cost-effectiveness, availability, acceptability, prioritizes health problems, access, prioritize vulnerable groups (children, pregnant women, disable individuals and adults), costs of services, cost-effectiveness of services, surveillance of demands and all needs, determine services at primary and secondly level exactly, cost of services execution, evidence-based, being accountable to people expectations, fund, services safety, efficacy, burden diseases and equity.

Table 7. Criteria of health service package of selected countries based on life expectancy.

Life expectancy(year)	Frequency	Percent	Criterion
Less than 60	14	46.7	Cost-effectiveness, coverage, financial supply, availability, access, decentralization, prioritize, attention to prevention and treatment concurrently, being accountable to people needs, popular prestige, preservation of effective interventions, acceptability, efficacy, effectiveness, people satisfaction, comprehensiveness, equity, burden diseases, quality, necessity and capacity.
60 t0 70	1	3.3	Access, prioritize, being accountable to society needs and efficacy.
70 to 80	11	36.7	Cost-effectiveness, merger, coverage, financial supply, innovation, availability, access, accountability, appropriateness, prioritize, meet society needs, effectiveness, solidarity, equity, civil rights, costs of services, accurate definition of services, evidence-based, burden diseases, applicable, fund of services, need, efficiency, insurance coverage, protection of at risk groups, better care, most importance.
More than 80	4	13.3	Efficacy, effectiveness, costs of services, funs of services and safety.

References:

1. Shadpour K, Pile Roudi S. Health for All and primary health care at 20 and 21 centuries, the tandis publishing, fall 1381. Pp187, 208. [In Persian].
2. The world health report 2008: Primary Health Care now more than ever. Available from: http://www.who.int/whr/2008/whr08_en.pdf.
3. Wong H, Bitran R. Designing a benefits package: background. Bitran yAssociados, October 1999; pp 1-14.
4. The Essential Benefit Package Recommendations of the Oregon Health Fund Board's Benefits Committee Available from: http://www.oregon.gov/OHPPR/HFB/docs/BenefitCommitteeFinal.pdf?ga=t

5. Bitran R, Wong H. 1999 "Designing a benefits health package". Prepared for the Flagship Course on Health Sector Reform and Sustainable Financing, World Bank Institute. Available from: http://info.worldbank.org/etools/docs/library/122031/bangkokCD/BangkokMarch05/Week1/4Thursday/S2ServiceDelivery/DesigningaBenefitPackage.pdf
6. Bobadilla J L. Searching for Essential Health Services in Low- and Middle-Income Countries A Review of Recent Studies on Health Priorities, Washington, D.C. June 1998 Nº Soc-1 . Available from: http://cdi.mecon.gov.ar/biblio/docelec/MU1334.pdf
8. Bobadilla J L. et al. Design, Content, and Financing of an Essential National Package of Health Services.Bulletin of the World Health Organization, 1994, 72 (4): 653-662. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2486601/pdf/bullwho00415-0117.pdf
9. Cowley P, Bobadilla JL, Musgrove P, Saxenian H. The Minimum Package of Health Services: Criteria, Methods and Data. World Bank Background Paper Number 1, World Bank, October 1994.
10. Mason J. Qualitative Research, 2/e, SAGE Publication 2002.
11. Nikfar S, Kebriaeezadeh A. et al. Monitoring of National Drug Policy (NDP) and its standardized indicators; conformity to decisions of the national drug selecting committee in Iran" BMC International Health and Human Rights 2005, 5:5
12. Pencheon D. 2006, Oxford Handbook of Public Health Practice , 2/e,
13. Eccles, M. 2001, "How to Develop Cost-Conciousguidelines"Health Technology Assessment, 2001, Vol 5, Number 16.
14. Culyer AJ .The Dictionary of Health Economics. Edward Elgar Pub 2005.
15. BenabbaS. Designing health Benefit Packages Article presented in 27th International social Security association General Assembly; Stockholm Sweden; 2001.
16. Wong H, Bitran R. Module 5 designing a benefits package, Prepared for the Flagship Course on Health Sector Reform and Sustainable Financing World Bank Institute, October 1999.
17. The Essential Benefits Package in the House Health Reform Bill (H.R. 3200) from families USA. September 2009.
18. Jabari H, Tabibi S J, Delgoshaee B, Mahmoody M, Bakhshian F. Acomparative study on decentralization mechanisms in provision of health services in health system of selected countries, and presenting a model for Iran . Journal of health administration. 2007; 10(27):33-40 [in Persian].
19. Roberts m, Hsiao w. Getting health reform right, oxford university press, 2002.
20. Basic package of health and social welfare services for Liberia, Ministry of Health and Social Welfare Republic of Liberia. Available from: http://www.basics.org/documents/Basic-Package-of-Health-and-Social-Welfare-Services_Liberia.pdf.
21. National Package of Essential health interventions in Tanzania, the united republic Of Tanzania, Ministry of health, January 2000. Available from: http://www.moh.go.tz/documents/national_package_essential_health.pdf
22. Basic Package of Essential Health Services for Sierra Leone Ministry of Health and Sanitation, Government of Sierra Leone Ministry of Health and Sanitation, March 2010.Available from: http://www.afro.who.int/index.php?option=com_docman&task=doc
23. Jing W, Yu Z, Wenxiu Y, Ying X, Yingjia L, Keqin R . Research on the Essential Health Services and National Package in China, Presentation made at Forum 11, Beijing, People's Republic of China, 29 October - 2 November 2007. Available from: www.globalforumhealth.org/content/download/Wu%20J%20-%20rf.pdf
24. Basic Package of Health and Nutrition Services For Southern Sudan , Ministry of Health, Government of Southern Sudan , Third Draft – February 2008Available from: http://ghiqc.usaid.gov/aidstar/docs/650-09-321/annex_f.pdf
25. A Basic Health Services Package for Iraq, Ministry of Health, January 2009.Available from: http://www.emro.who.int/iraq/pdf/basic_health_service_package_en.pdf
26. Kozierkiewicz A , Trabka W, Romaszewski A, Gilewski D, Golen M, Juszczyk G. Benefit package and costs of services-health Bascet Report 1-Poland, March 2005.Available from: http://www.ehma.org/files/Benefit_Report_Poland.pdf
27. The Lesotho essentional services package; Ministry of health and social welfare, Lesotho, Final report, June 2003.Available from: http://www.mca.org.ls/documents/Health/ESSENTIAL%20SERVICE%20PACKAGE.pdf
28. Ensor T, Dave-sen P, Ali LHossain A, Bengum S, Mora H. Do essential service package benefit the poor? Preliminary evidence from Bangladesh, Health Policy and Planning. 17(3): 247-256.

29. Onwujekwe O, Onoka C, Uguru N, Nnenna T, Uzochukwu B, Eze S, Kirigia J, Petu A. Perseearfceharreticnleces for benefit packages for community-based health insurance: an exploratory study in Nigeria. BMC Health Services Research 2010, 10:162.
30. Hrabae B, Ljubic B, Bagaric Ivan. Basic Package of Health Entitlements and Solidarity in the Federation of Bosnia and Herzegovina, Croat Med J 2000; 41:287-293.
31. Hastings TR Banda, Grace T Bongololo, Judy Ng'ombe and Ireen Makwiza .Country Health Equity AnalysisMalawi, September 2006 Available from: www.equinetafrica.org/bibl/docs/REQMalawi06.pdf
32. Moccero D. Delivering cost-efficient public services in health care, education and housing in Chile. Paris, Organization for Economic Co-operation and Development, 2008(Economics Department Working Papers No.606). Available from: http://www.eric.ed.gov/PDFS/ED503922.pdf
33. Taking the Kenya Package for Health to the Community, A Strategy for the Delivery of Level one Services, Ministry of Health Afya House Nairobi, Kenya. April 2006.Available from: www.publichealth.go.ke/index2.php?option=com
34. Basic Health Services, Provision of Basic Health Services in the provinces of Siem Reap, OtdarMeanchey and Kampong Cham Available from: http://www.btcctb.org/files/web/Provision%20of%20Basic%20Health%20Services%20in%20the%20provinces%20of%20Siem%20Reap,%20Otdar%20Meanchey%20and%20Kampong%20Cham.pdf
35. Frenk J, Gonzalez-Pier E , Gomez-Dantes O , Lezana M A, Knaul F M . Comprehensive reform to improve health system performance in Mexico. Lancet 2006; 368: 1524–34.
36. Schreyögg J, Star gardt T, Velasco-Garrido M, Busse R. Defining the "Health Ben e fit Basket" in nine European countries. Eur J Health Econ 2005 · [Suppl 1] 6:2–10.
37. Hansen P M, Peters D H, Niayesh H, Singh L P, Dwivedi V, Burnham G. Measuring and managing progress in the establishment of basic health services: the Afghanistan Health Sector Balanced Scorecard . International journal of health planning and management Int J Health Plan Mgmt 2008. Available from: http://www.cpc.unc.edu/measure/networks/datausenet/dashboards-and-data-use-forum-may-2010/Afghanistan%20Balanced%20Scorecard%20-%20IJHPM.pdf
38. Ssengooba F. Uganda's minimum health care package: rationing within the minimum? Lecturer, Institute of Public Health, Makerere University Medical School, Uganda Available from:http://www.bioline.org.br/pdf?hp04005
39. The primary care package for South Africa-a set of norms and standards, department of heath Pretoria, march 2000.
40. Essential health services package for Ethiopia, federal ministry of health, august 2005.
41. Essential health benefit, institute of medicine of the national academies.
42. Ahmadvand. A. "Equity and efficiency of health system reform Guide "big ebnesina publisher. pp211
43. Frost l j. Access: How do good health technologies get to poor people in poor countries? 2008: Harvard center for population and development studies-can bridge, Massachusetts.
44. Baghbanian A,(1382) " Management in Healthcare", 2edition, Ghap publisher, pp651
45. Karimi.I,(1384), "Health Economics", 1 Edition, pp72
46. Shad,P(1376)," Cost analysis in primary health care", Aghigh Publisher, pp65
47. Sadeghi H, Abdullahi S, Abdullah ZadehL. HumanDevelopment in Iran. Journal of Social Welfare2007;4 : 283-304[Persian]
48. Hajizadeh. M(1387)," Health Economics",Jame negar publisher,pp20

7/29/2013