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Making fair choices on the path to universal health coverage: A Précis

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1. Background and aims

Universal Health Care (UHC) is high on the global agenda and on many countries' national agendas (WHO, 2010; Lagomarsino *et al.*, 2012). The World Health Organisation (WHO) has defined UHC as "all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for them" (WHO, 2013). This definition leaves room for interpretation. On our understanding, given resource constraints, UHC does not require that all possibly effective services are provided to everyone. Rather, UHC requires that a comprehensive range of services, well-aligned with other social goals, is available to all at bearable cost.

The compelling case for UHC as a goal derives from the value of fairness (or equity). This value is also critical on the path to that goal. Motivated by this insight, and as part of the response to requests from more than 70 countries for support and advice for UHC reform, the WHO set up a Consultative Group on Equity and Universal Health Coverage in 2012. The group consisted of philosophers, economists, health policy experts, and clinical doctors of twelve nationalities. The group's report, *Making fair choices on the path to universal health coverage*, was published in May 2014 (WHO, 2014b).

The Report aims to clarify issues of fairness that arise on the path to UHC. It also offers recommendations for how countries can address them. It is premised on the fact that decision-makers face (sometimes severe) resource constraints. It aims to outline acceptable ways to proceed

given these restrictions. (This does not imply that the constraints themselves are justified—in many countries, there is a strong case for mobilizing more internal and external resources (Røttingen *et al.*, 2014).) Of course, what a decision-maker can implement may be determined by factors other than resource constraints, such as political limitations imposed by the interests of particular groups. In such cases, the Report can play a twofold role. First, it can help evaluate the fairness of the policies favoured by such interest groups. Second, it can provide guidance on how to choose from the set of options that remain feasible given the joint operation of resource and political constraints. (We imagine that of these two roles, the latter will be most helpful to policy-makers.)

In recognition of these feasibility constraints, variations in local context, and the diverse values that should determine policy choice, the Report takes a pluralist, comparative and incremental approach to policy evaluation (Sen, 2009).

2. Critical choices and guiding principles

To achieve UHC, countries must expand priority services, include more people, and reduce out-of-pocket payments. In doing so, they confront critical choices:

- i. Which services to expand first?
- ii. Whom to include first?
- iii. How to shift from out-of-pocket payment toward prepayment?

The Report argues that the following principles should play a central role in making these choices.

- I. *Fairness in coverage and service provision:* Coverage and use should be based on need; extra weight should be given to the needs of the worse off.
- II. *Benefit maximization:* One aim should be to generate the greatest sum of health-related well-being in a given population.
- III. *Fair contribution:* Contributions should be based on ability to pay and not need.

In what follows, we outline the Report's recommendations, which draw on these principles.

3. Which services to expand first?

The Report advises sorting health services into three priority tiers: high, medium, and low. It proposes to accomplish this by first creating a partial classification on the basis of cost-effectiveness (defined as cost per healthy life year), and then rendering the classification more complete by an appeal to other principles. Of central importance among these are improving the situation of the worse off and financial risk protection. Box 1 illustrates this procedure.

[Box 1 about here.]

There are several reasons for using such a procedure. Cost-effectiveness is strongly linked to maximizing the sum-total of health gained in a population, which should be a key (though not the only) policy objective. For a given budget, prioritizing services by cost-effectiveness provides the greatest health improvement. Moreover, there is extreme variability between health services: the cost-effectiveness of interventions in the WHO Choice database, for example, is spread over four orders of magnitude (WHO, 2014a). A failure to prioritize on cost-effectiveness can therefore imply forgoing large health gains. Moreover, focusing on the expansion of highly cost-effective services will often disproportionately benefit the poor. Nonetheless, there are cases in which pursuing only maximal cost-effectiveness would come at a cost to the worst off (for example, because providing services to poor, remote areas is more expensive) or to financial risk protection. In such cases, the procedure permits concern for the worse off or for financial risk protection (and other relevant concerns) to determine into which priority class a service should fall. The Report does not specify exactly how much weight should be assigned to each of the relevant concerns, rather stressing that many ways of weighing these concerns may be reasonable. Nonetheless, it is clear from Box 1 that the Report envisions that concerns for properties other than cost-effectiveness may be given considerable weight. Moreover, it argues that certain ways of weighing competing values are (im)plausible. (For example, it argues that since for a given individual, it is plausibly worse to die than to become impoverished, in a trade-off between lives saved and financial risk protection, one should favour saving a life over averting one case of poverty; see Box 3.2 in the Report.) It also describes processes of and institutions for priority-setting. Once sufficient progress has been made in classifying services, the Report argues that (near) universal coverage for high-priority services should be at the top of countries' lists.

4. Whom to include first?

In many countries, progress towards this aim must take place against a background of significant coverage gaps, especially among the poor, rural populations, and groups marginalized due to race, gender, or social status. For example, in Ethiopia in the five-year period up to 2011, the proportion of live births attended by skilled health personnel was 10 percent. Moreover, there were clear social and geographical differences: in the lowest wealth quintile, 2 percent of all births were attended by a skilled provider, as opposed to 46 percent in the highest wealth quintile; in the rural population, attendance was 4 percent, whereas in the urban population, this was 51 percent (Central Statistical Agency, 2012).

In expanding coverage for such high-priority services against a backdrop of inequality, the Report argues that disadvantaged groups should get extra weight in policy formulation. This implies that an expansion of such services to an underserved poor and rural population should take priority over an expansion to a well-off, urban population, at least where other things are roughly equal.

5. How to shift from out-of-pocket payments to pre-payment?

In countries without UHC, many face a risk of catastrophic health service payments. To use the example of Ethiopia again, in recent years, nearly a quarter of the Ethiopian population have faced annual health care payments of > 40% of non-food expenditure (World Bank, 2014). A shift from out-of-pocket payment to mandatory prepayment with pooling of funds can alleviate these risks. When making this shift, the Report argues that countries should first reduce out-of-pocket payments for high-priority services. This is because such payments are barriers to access for these services, the provision of which is of primary importance for reasons related to health benefits, costs, the situation of the worst off, and financial risk protection. At the same time, countries should strive to make prepayments depend on ability to pay. Together, these two moves help ensure that everyone has affordable access to the most important services based on need.

In some environments, the latter goal may be difficult to achieve. For example, a lack of reliable income data for individuals in the informal sector is cited by Dr. Addis Tamire Waldemariam (p.) as a reason for the 2014 Ethiopian decision to make enrolment for informal-sector, community-based health insurance subject to a flat fee (from which the very poorest are exempted). Nonetheless, a fully progressive prepayment system should remain a goal. Rwanda, which started with a flat fee for community-based insurance and then, with donor subsidies, moved to an income-dependent fee, indicates that advance towards this aim may be possible (Kalk *et al.*, 2010).

6. Unacceptable ways of making trade-offs

There is no single right path to UHC. However, the Report argues that some ways of making trade-offs are *generally unacceptable* (inconsistent with the principles outlined). They include the following:

- Choosing to expand coverage for low- or medium-priority services before there is near-universal coverage for high-priority services.

- Choosing to give high priority to very costly services whose coverage will provide substantial financial risk protection when the health benefits are small compared to alternative, less costly services.
- To expand coverage only for formal sector workers and others with the ability to pay and not include informal workers and the poor, when it is feasible to simultaneously expand coverage for the latter.

In some settings, political pressures to make such choices may exist, even though they are typically unfair. But experience indicates that progress can be made while avoiding such unfairness. For example, by simultaneously expanding a formal-sector insurance plan and scaling up community-based health insurance for the informal sector, Ethiopia is aiming to make progress for disadvantaged groups as well as for the better off.

7. Accountability

When pursuing UHC, reasonable decisions and their enforcement can be facilitated by robust public accountability and participation mechanisms. The Report advocates institutionalization of these mechanisms. Institution-building of this kind is challenging, but the Report outlines many strategies that can be pursued, and it provides examples of countries that have made progress. For example, it emphasizes how accountability and participation can be strengthened through a standing national committee on priority setting, and how the design of this and other institutions can be informed by the Accountability for Reasonableness framework (Daniels and Sabin, 2008). Moreover, the Report highlights how a strong system for monitoring and evaluation can promote accountability and the effective pursuit of UHC.

8. Conclusion

The Report proposes a three-part strategy for countries seeking fair progressive realization of UHC:

- a. Categorize services into priority classes. Relevant criteria include cost-effectiveness, improving the lot of the worse off, and financial risk protection.
- b. First expand coverage for high-priority services to everyone. This includes eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds.
- c. While doing so, ensure that disadvantaged groups are not left behind.

The Report also recommends that countries set up systems to monitor results and design institutions that can help strengthen public accountability and participation.

As members of the Consultative Group, we hope that this guidance will assist countries in moving toward UHC. We also hope that our arguments will stimulate debate about the difficult choices that arise on the path to that goal.

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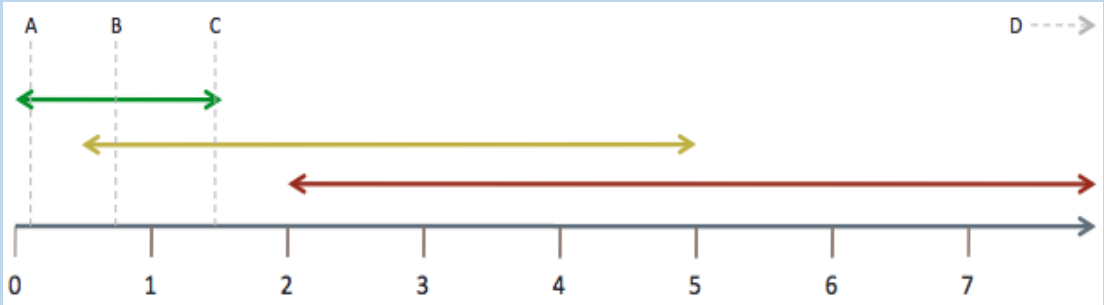
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Box 1. Application of the procedure to hypothetical cases in Kenya

Using regional or developing-country estimates of cost-effectiveness and national income data for Kenya, four services (A, B, C, and D) have been placed on a scale denoting cost per healthy life year in multiples of GDP per capita (WHO, 2014a; Teerawattananon, *et al* 2007). The arrows indicate which priority class the services are initially associated with. Green, yellow, and red arrows are associated with high, medium, and low priority, respectively. A service located in an overlapping interval needs further assessment against other criteria. (The exact cut-offs between classes in the figure are illustrative only and need to be determined within each country.) With cut-offs established, the decision-maker may reason as follows.



Cost per healthy life year in multiples of GDP per capita

A: *Tuberculosis diagnosis and treatment*

Costing less than 10% of GDP per capita per healthy life year, this is a high-priority service.

B: *Traffic safety regulation*

At a cost of 80% of GDP per capita per healthy life year, this falls in a region where cost-effectiveness alone is not determinative. Assessment against additional criteria is therefore required. Priority to the worse off is relevant here, as traffic accidents often cut down people in their youth (Murray *et al.*, 2012). We would therefore expect the service to receive high priority.

C: *Treatment for mild asthma*

Costing 149% of GDP per capita per healthy life year, treatment for mild asthma is only just within a range in which cost-effectiveness alone is not determinative. Moreover, the typical disease burden is moderate (Murray *et al.*, 2012). It would therefore have to score especially well on additional criteria, such as financial risk protection, in order to be placed in the high-priority category.

D: *Dialysis for renal failure*

Costing more than 30 times the GDP per capita per healthy life year, dialysis falls in the low-priority category. Money spent on dialysis could instead save 300 times as many healthy life years if spent on tuberculosis control.

