Making fair choices on the path to universal health coverage

Final report of the WHO Consultative Group on Equity and Universal Health Coverage

World Health Organization

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Preface

Universal health coverage (UHC) is at the center of current efforts to strengthen health systems and improve the level and distribution of health and health services. This document is the final report of the WHO Consultative Group on Equity and Universal Health Coverage. The report addresses the key issues of fairness and equity that arise on the path to UHC. As such, the report is relevant for every actor that affects that path and governments in particular, as they are in charge of overseeing and guiding the progress toward UHC.

Background

The goal of UHC has a strong basis, and the underlying aspirations have a long history. The constitution of the World Health Organization (WHO) asserts that a right to health is "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." This message has since been repeatedly reinforced; perhaps most prominently in the 1978 Declaration of Alma-Ata. Since the turn of the century, the quest for UHC has gained momentum in numerous countries and in the global health community. In 2005, the member states of WHO endorsed UHC as a central goal and stated that health systems must "be further developed in order to guarantee access to necessary services while providing protection against financial risk."

The World Health Report 2010 followed up by providing practical guidance for how countries can reform their health financing systems in order to pursue UHC. Since then, more than seventy countries have requested policy support and technical advice for such reform from WHO. In 2011, the World Health Assembly responded by calling on WHO to develop a plan of action for providing such support and advice. One of the action plan's twelve points is action on equity, a key issue that cuts across most other components of a health system. Specifically, the WHO Consultative Group on Equity and Universal Health Coverage was set up to develop guidance on how countries best can address the central issues of fairness and equity that arise on the path to UHC.

Since 2011, the pressing need to make progress toward UHC has been repeatedly affirmed, for example, in the Bangkok Statement on Universal Health Coverage and the Mexico City Political Declaration on Universal Health Coverage. Moreover, in late 2012, the United Nations General Assembly adopted a resolution emphasizing the responsibility of governments to "urgently and significantly scale up efforts to accel-

erate the transition towards universal access to affordable and quality health-care services." Later, WHO published the World Health Report 2013, *Research for Universal Health Coverage*, which again emphasized the need to make progress toward UHC and described several means to that end. Further underscoring WHO's commitment, advancing UHC has been identified as a leadership priority for WHO in the 12th general programme of work during the 2014-2019 period. UHC is also a central theme in the ongoing deliberation over the post-2015 development agenda.

In parallel with the work of WHO and other actors in the multilateral system, many countries have intensified their efforts in progressing toward UHC. The results have been encouraging and supported the Director-General's assertion that UHC is "the single most powerful concept that public health has to offer."

Process

As described, WHO's plan of action motivated the establishment of the Consultative Group. The group consisted of eighteen ethicists, economists, policy experts, and clinical doctors, spanning thirteen nationalities. The group worked on the report from May 2012 until January 2014 and convened three times. The meetings took place in Stavanger (Norway), Boston (US), and Geneva (Switzerland). At several stages in the process, drafts were also circulated for external review, including to selected national ethics committees and to the WHO Collaborating Centers for Bioethics. In addition, feedback was obtained from numerous other individuals and groups working in relevant areas.

Content

This report addresses the critical choices of fairness and equity that arise on the path to UHC. Accordingly, the report is not primarily about why UHC ought to be a goal, but about the *path* to that goal. The report may differ from others in the direct way it addresses fundamental issues and difficult trade-offs. This approach was facilitated by the involvement of philosophers and ethicists in addition to economists, policy experts, and clinical doctors.

Target audience

Numerous actors influence the progress toward UHC. Among them are institutions, groups, and individuals, within and outside government, locally, nationally, and internationally. The issues of fairness and equity addressed in this report are highly relevant to all of these actors. The report is most relevant, however, for governments in charge of overseeing and guiding the progress toward UHC. More specifically, the report can be particularly useful for policy makers and technical advisors in health ministries.

Brief summary

Since 2010, more than seventy countries have requested policy support and technical advice from the World Health Organization (WHO) for how to move toward universal health coverage (UHC). As part of the response, WHO set up a Consultative Group on Equity and Universal Health Coverage.

This final report by the Consultative Group addresses the key issues of fairness and equity that arise on the path to UHC by clarifying these issues and offering recommendations for how countries can manage them.

To achieve UHC, countries must advance in at least three dimensions. Countries must expand priority services, include more people, and reduce out-of-pocket payments. However, in each of these dimensions, countries are faced with a critical choice: Which services to expand first, whom to include first, and how to shift from out-of-pocket payment toward prepayment? A commitment to fairness—and the overlapping concern for equity—and a commitment to respecting individuals' rights to health care must guide countries in making these decisions.

The following three-part strategy can be useful for countries seeking fair progressive realization of UHC:

- Categorize services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to the worse off, and financial risk protection.
- 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.
- While doing so, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations.

As part of an overall strategy, countries must carefully make choices within and across the dimensions of progress. These decisions depend on context, and several different pathways can be appropriate. Nevertheless, some trade-offs are generally unacceptable. For example, one generally unacceptable trade-off is expanding coverage for low- or medium-priority services before there is near-universal coverage for high-priority services.

When pursuing UHC, reasonable decisions and their enforcement can be facilitated by robust public accountability and participation mechanisms. These mechanisms should be institutionalized, for example, through a standing national committee on priority setting, and the design of legitimate institutions can be informed by the Accountability for Reasonableness framework. A strong system for monitoring and evaluation is also crucial for promoting accountability and participation and is indispensable for effectively pursuing UHC.

Executive summary

Universal health coverage (UHC) is defined as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services. Given resource constraints, this does not entail all possible services, but a comprehensive range of key services that is well aligned with other social goals. UHC was firmly endorsed by the World Health Assembly in 2005 and further supported in the World Health Report 2010. Since then, more than seventy countries have requested policy support and technical advice for UHC reform from the World Health Organization (WHO). In response, WHO developed a plan of action that included providing guidance on how countries can manage the central issues of fairness and equity that arise on the path to UHC. The WHO Consultative Group on Equity and Universal Health Coverage was set up to develop this guidance.

This document is the Consultative Group's final report. The report addresses the key issues of fairness and equity by clarifying these issues and offering recommendations for how countries can manage them. The report is relevant for a wide range of actors and particularly for governments in charge of overseeing and guiding the progress toward UHC.

To achieve UHC, countries must advance in at least three dimensions. Countries must expand priority services, include more people, and reduce out-of-pocket payments. However, in each of these dimensions, countries are faced with a critical choice: Which services to expand first, whom to include first, and how to shift from out-of-pocket payment toward prepayment? A commitment to fairness—and the overlapping concern for equity—and a commitment to respecting individuals' rights to health care must guide countries in making these choices. For fair progressive realization of UHC, the three critical choices and the trade-offs between the dimensions must be carefully addressed.

Expanding priority services

When expanding services, the crucial question is which services to expand first. Services can be usefully categorized into three classes: high-priority, medium-priority, and low-priority services. Relevant criteria for ranking and categorizing services include those related to cost-effectiveness, priority to the worse off, and financial risk protection.

When selecting which services to expand next, it is often useful to start with cost-effectiveness estimates and then integrate the concern for the worse off as well as other relevant criteria. The specification, balancing, and use of these criteria should take place in the context of robust public deliberation and participatory procedures. This will enable a wide range of groups to provide input to the priority-setting process and

promote accountability for the decisions made. Countries will also benefit from having a standing national committee on priority setting to handle particularly difficult cases.

Including more people

When seeking to include more people, an inescapable question is whom to include first. To include more people fairly, countries should primarily first expand coverage for low-income groups, rural populations, and other groups disadvantaged in terms of service coverage, health, or both. This is especially important for high-priority services. Fair inclusion of more people may call for targeted approaches where these are effective.

Reducing out-of-pocket payments

Many countries rely heavily on out-of-pocket payments to finance health services. Such payments represent a barrier to access to health services, especially for the poor. In addition, for those who do use the services, out-of-pocket payments are often a substantial financial burden on them and their families and may even cause financial catastrophe. To improve access and financial risk protection, countries should therefore shift from out-of-pocket payment toward mandatory prepayment with pooling of funds. A critical issue is how to do so. Fairness suggests that out-of-pocket payments should first be reduced for high-priority services and for disadvantaged groups, including the poor. Regarding mandatory prepayments, fairness suggests that they should generally increase with ability to pay and that contributions to the system should be progressive. At the same time, the access to services should be based on need and not ability to pay.

Overall strategy and pathways

A three-part strategy can be useful for countries seeking fair progressive realization of UHC:

- Categorize services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to the worse off, and financial risk protection.
- 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.
- While doing so, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations.

As part of an overall strategy, countries must carefully make choices within as well as across the dimensions of progress. These choices will depend on context, and several different pathways can be appropriate. However, when pursuing fair progressive realization of UHC, some trade-offs are *generally unacceptable*:

- *Unacceptable trade-off I*: To expand coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing out-of-pocket payments for low- or medium-priority services before eliminating out-of-pocket payments for high-priority services.
- *Unacceptable trade-off II*: To give high priority to very costly services whose coverage will provide substantial financial protection when the health benefits are very small compared to alternative, less costly services.

- *Unacceptable trade-off III*: To expand coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.
- *Unacceptable trade-off IV*: To first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier.
- *Unacceptable trade-off V*: To shift from out-of-pocket payment toward mandatory prepayment in a way that makes the financing system less progressive.

Mechanisms and institutions

Fair progressive realization of UHC requires tough policy decisions. Reasonable decisions and their enforcement can be facilitated by robust public accountability and participation mechanisms. These mechanisms are essential in policy formulation and priority setting and specifically in addressing the three critical choices on the path to UHC and the trade-offs between dimensions of progress. These mechanisms are also crucial in tracking resources and results. To properly play these roles, public accountability and participation should be institutionalized, and the design of legitimate institutions can be informed by the Accountability for Reasonableness framework.

A strong system for monitoring and evaluation is also needed to promote accountability and participation and is indispensable for effectively pursuing UHC in general. Countries must carefully select a set of indicators, invest in health information systems, and properly integrate the information into policy making. The selection of indicators should be closely aligned with the goal of UHC and in most settings include at least four types of indicators: indicators related to the priority-setting processes and indicators of coverage, financial risk protection, and health outcomes. The latter three types of indicators should reflect both average levels and equity in distribution.

List of abbreviations

AIDS	Acquired immunodeficiency syndrome
CI	Concentration index
ECOSf	Equipos Comunitarios de Salud familiar
GDP	Gross domestic product
HALE	Health-adjusted life expectancy
HIV	Human immunodeficiency virus
HRH	Human resources for health
HTA	Health technology assessment
NCD	Noncommunicable disease
PAHO	Pan American Health Organization
TB	Tuberculosis
UHC	Universal health coverage
WHO	World Health Organization

1 Universal health coverage

Universal health coverage (UHC) is defined as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services.[1] Given resource constraints, this does not entail all possible services, but a comprehensive range of key services that is well aligned with other social goals. The member states of the World Health Organization (WHO) have endorsed UHC as a goal and stated that health systems must "be further developed in order to guarantee access to necessary services while providing protection against financial risk."[2] This report addresses the critical choices regarding fairness and equity that arise on the path to UHC.

The definition of universal health coverage

As described, UHC has been defined as "all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them."[1] [i] [ii] The interpretation of this definition is important. This is especially the case for the element "services that meet their needs," as the concept of need is ambiguous.[5-7] "Need" can, for example, refer to the shortfall from normal health, the capacity to benefit from a service, or a combination. Moreover, under most interpretations, available resources in every country fall short of what is required to meet all needs. Therefore, it is crucial that resources are concentrated on the most important set of services and that the resources devoted to the pursuit of UHC do not jeopardize other important social goals. If UHC is to be achievable, the definition of UHC must be sensitive to these concerns. Accordingly, this report does not take UHC to require all services that are expected to be beneficial. Instead, the report takes UHC to require a comprehensive range of key services that is well aligned with other social goals.

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[i] Instead of "universal health coverage," the terms "universal coverage," "universal health care," and "universal access" are sometimes used. Given the understanding of "universal health coverage" in this report, universal access and universal health care can be seen as components of UHC.

[ii] The definitions of "universal health coverage" and "universal coverage" vary. The 2005 58th World Health Assembly indirectly defined universal coverage as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost."[3] Somewhat differently, the World Health Report 2010 specified "universal coverage" as a goal according to which "all people have access to services and do not suffer financial hardship paying for them," and the report generally focused on "access to needed services" and "financial risk protection."[4] Since then, most definitions have had a similar structure with some variation in wording. Although these variations may appear minor, at least four types of variation should be acknowledged. First, some definitions assert that everyone must have "access" to services as opposed to "receiving" services. Second, some definitions refer to "needed services," "key services," or "necessary services," as opposed to "services that meet [people's] needs." This is further discussed below. Third, some definitions refer to "financial catastrophe," "financial ruin," or "poverty" rather than "financial hardship." Fourth, not all definitions explicitly link the financial harm to payment for services.

The goal of universal health coverage

Although this report is not primarily about why countries should pursue UHC, it is useful to outline the strong and multifaceted rationale for that goal. First, securing access to health services is motivated by the individual benefits from service utilization. These improvements in health can be seen as an end in themselves as well as crucial to overall well-being and the related concepts of capabilities and opportunities.[5, 8-10] Health can affect overall well-being directly and indirectly, for example, through income and wealth. Health can also be seen as of great importance due to its impact on people's range of opportunities—such as their ability to work or pursue an education—or the range of life plans open to them.[5]

From the same perspectives, it is also evident why *affordable* access is so important. Like poor health, large payments for services can severely limit well-being and opportunities, not only for the individual who uses the service, but also for his or her family.[11-13] Affordable access across the entire continuum of care also facilitates the use of preventive services, and these services are often more cost-effective than the corresponding curative services. Moreover, affordable access confers benefits even to those who do not eventually need health services. Among other things, knowledge of affordable access can reduce anxiety and the fear of becoming ill and make people sleep better at night. Such knowledge can also facilitate planning and productive use of resources that otherwise would have to be kept in reserve in case the need for expensive services arises.

Widespread coverage is also beneficial to society at large. Improved coverage improves population health,[14] and health contributes to development directly,[10, 15] as indicated by, for example, the Human Development Index (HDI).[16] In addition, health affects development and the overall well-being of society indirectly. Healthy children are better able to learn,[17, 18] and a healthy population facilitates economic growth.[19, 20] According to one study, for every dollar spent on key services, the direct and indirect economic returns—measured as "full income"—can be multiplied by a factor of 9-20.[21] In other words, there can be enormous payoffs from investing in health.

UHC can further be motivated by its distributional effects. Irrespective of the total benefits to society, *universal* health coverage can be supported by the idea that coverage should not be restricted to the better-off part of the population or, more specifically, by the idea that such a restriction is unfair.[5, 22] Insofar as it improves coverage for the worse off, progress toward UHC can also promote fairer distribution of health and well-being.

UHC is also a way to meet rights to health care and the human right of "the enjoyment of the highest attainable standard of physical and mental health,"[23] which is recognized under international law.[24] Every country in the world has ratified at least one treaty that specifies obligations regarding the right to health. Under international law, states have an obligation to adopt appropriate measures to realize the right to health or the right to health care on a non-discriminatory basis (as some treaties specify). This obligation involves a strategy and plan of action for how to achieve that goal as well as mechanisms for oversight and redress.[25] Parties to specific international treaties also have obligations to allocate sufficient resources to realize the right to health. In other words, states have an obligation to adopt appropriate measures to realize the right to

health, and the pursuit of UHC is crucial to this endeavor. Accordingly, many different approaches, including those based on fairness or rights, can endorse and encourage the urgent pursuit of UHC.

The scope of universal health coverage

UHC must be understood in a comprehensive way. More specifically, the goal of UHC calls for quality services of many kinds, for strengthening the entire health system, and for intersectoral action.

As for services, UHC goes beyond clinical and curative services to include public health and population measures and promotive, preventive, and rehabilitative services.[3, 4] Public health coverage and population measures include, for example, informational campaigns on hygiene and food safety, vector control, and tobacco regulation. Services, broadly understood, also include the provision of drugs, devices, and other goods. Especially regarding essential medicines, considerable effort has been exerted to promote universal access.[26, 27] For all services, quality, not only quantity, is paramount. When moving toward UHC, countries must ensure that everyone has access not merely to services, but to services that are truly effective and of good quality.[28, 29]

UHC is centrally but certainly not exclusively concerned with financing. The financing function of health systems includes revenue collection, pooling of resources, and purchasing of services,[30] all of which are critical to the pursuit of UHC. However, UHC and the means necessary to make progress go beyond financing. UHC is concerned with coverage in general and is thus concerned with all barriers to coverage. Many of these barriers are primarily nonfinancial—including legal, organizational, technological, informational, geographic, and cultural barriers—and are not necessarily best addressed through financial means.[31-34] Therefore, all functions of the health system must be strengthened. In addition to financing, the four key functions include service provision, generation of human and physical resources, and stewardship.[35] Stewardship requires that the government oversees and guides those other functions. The categorization of functions also highlights the importance of human resources in health system strengthening.[36, 37]

UHC calls for action going beyond the health sector and the health system, as the means for improving access to health services and financial protection are not confined to that sector and system. For example, affordable access may crucially depend on policies in sectors concerned with transportation, employment, education, and finance. The pursuit of UHC therefore requires intersectoral action.[38, 39] In addition, the underlying objective of improving health—and not only health services—requires approaches that go beyond the health sector also more generally. Countries must address the broader determinants of health, including social determinants such as education, employment, housing, and environment.[40, 41] Accordingly, any pursuit of UHC must be well aligned with such endeavors.

Finally, although most UHC initiatives concentrate on domestic health policy, the broader, ultimate goal of comprehensive coverage for everyone in the world should be kept in view. Today, differences in health and service coverage are profound both across and within countries. For example, in 2010, healthy life expectancy at birth for males ranged from 37.7 healthy life years in the Central African Republic to 70.6 in

Japan.[42] [iii] Likewise, under-five mortality rate (U5MR) varied from 180 to 2 per 1,000 live births.[43] Differences in service coverage are no less pronounced. For example, the percentage of one-year-olds who has received the third those of diphtheria-tetanus-pertussis vaccine varies (DTP3) from 33 percent to 99 percent, and the percentage of births attended by skilled health personnel ranges from 9 percent to 100 percent.[43] What is particularly troubling is that inequalities in health and inequalities in service coverage are often correlated, so that coverage is the least where needs are the greatest. These inequalities and the variation in country capacity to address health needs raise a number of important issues.[44] In particular, there is a question about how capable countries can and should assist countries that alone are unable to adequately address domestic needs. Concerns for global justice, global solidarity, and human rights can, for example, motivate development assistance for health with the aim of closing the glaring gaps in service coverage.[45, 46]

Dimensions of progress and critical choices

Several countries have recently demonstrated that significant steps toward UHC can be taken, even in resource-constrained settings.[47, 48] Among these countries are Cambodia, Chile, China, Colombia, Ghana, Indonesia, Mexico, the Philippines, Rwanda, Thailand, and Vietnam.[iv]

Obviously, no country starts from zero coverage, and there is no single path to UHC that every country must follow. To achieve UHC, however, every country must make progress in at least three dimensions. Countries must expand priority services, include more people, and reduce out-of-pocket payments. These three dimensions closely correspond to those often emphasized in the context of financing and, more specifically, the dimensions of the now well-known UHC box.[4] This box is shown in figure 1.1. The box illustrates three dimensions to consider when moving toward UHC. These concern (a) the proportion of the population to be covered, (b) the range of services to be made available, and (c) the proportion of the total costs to be met. More specifically, the first dimension is linked to the proportion of people covered from pooled funds, while the third dimension refers to the proportion of total costs to be met by pooled funds.

As indicated, in this report the three dimensions are interpreted somewhat more broadly. Although expanding priority services typically requires changes in financing, expansion can also follow from other changes. For example, coverage for priority services can be expanded through a change in the use of health personnel or the use of existing technologies and infrastructure. Moreover, reducing barriers to coverage requires action on many nonfinancial barriers and the use of nonfinancial means. These barriers include stigma and cultural norms, for example.

In each dimension, countries moving forward will face at least one critical choice regarding fairness and equity. When expanding priority services, countries must decide which services to expand first. When including more people, countries must decide whom to include first. And when reducing out-of-pocket payments, countries

[iii] Due to the earthquake, healthy life expectancy in Haiti was as low as 27.8 years in 2010.

[iv] Many case studies on UHC reforms in these and other countries exist. Useful collections include UHC Forward,[49] a WHO compilation of success stories,[50] and the World Bank's study series on UHC.[51]

Figure 1.1 Three dimensions to consider when moving toward universal health coverage

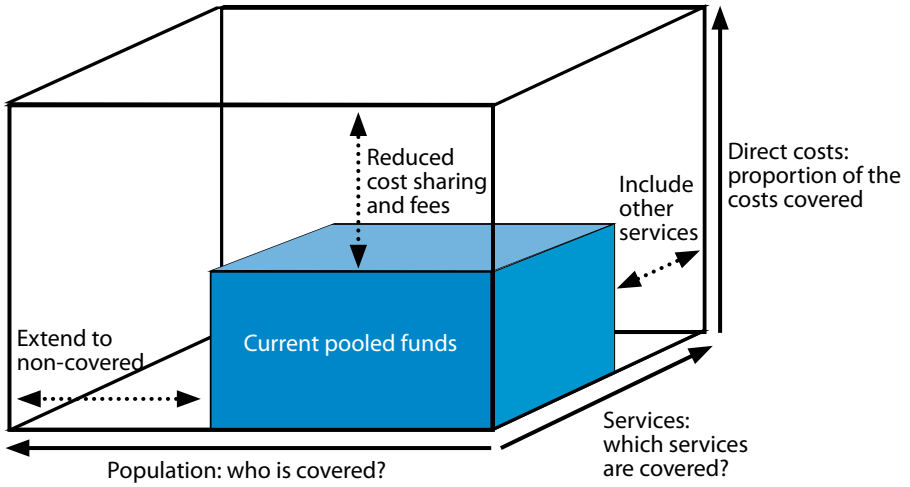

Figure adapted from the World Health Report 2010[4]

must decide how to shift from such payment toward prepayment. The dimensions of progress and the related choices are summarized in box 1.1.

Box 1.1 Critical dimensions and choices on the path to universal health coverage

Dimension of progress	Critical choice
Expanding priority services	Which services to expand first?
Including more people	Whom to include first?
Reducing out-of-pocket payments	How to shift from out-of-pocket payment toward prepayment?

Expanding priority services

Progress toward UHC can be sought by expanding priority services. However, no country can cover all services that are expected to be beneficial. For each step toward UHC, countries must therefore choose among different services that all need to be expanded. Countries are then faced with the following choice: Which services to expand first?

Including more people

Progress toward UHC can be sought by including more people. To do so, countries must seek to reduce all barriers to effective coverage. Among these barriers are prohibitive payments for services and other financial barriers and many nonfinancial barriers. The latter include legal, organizational, technological, informational, geographic, and cultural barriers. Since these barriers cannot be eliminated for everyone immediately, countries are faced with the following choice: Whom to include first?

Reducing out-of-pocket payments

Progress toward UHC can be sought by reducing out-of-pocket payments while increasing mandatory prepayment, for example, in the form of taxes or premiums. When doing so, countries are faced with the following choice: How to shift from out-of-pocket payment toward prepayment?

The context of choice

Numerous actors influence the progress toward UHC. These actors are institutions, groups, and individuals, within and outside government, locally, nationally, and internationally. Their choices are shaped by multiple considerations, which include economic and political circumstances and the actors' economic and political interests[52-54] as well as their ideals.[55, 56] Central among these ideals are those related to fair and equitable distribution of benefits and burdens in society. This report addresses issues of fairness and equity arising on the path to UHC. For all actors affecting that path, it is crucial to be keenly aware of these issues and to make the accompanying decisions with care. Central among these actors are obviously health workers. This report, however, mainly addresses the choice situations relevant for governments in charge of overseeing and guiding the progress toward UHC. In particular, the report can be useful for policy makers and technical advisors in ministries of health.

2 The critical role of fairness and equity

Fairness and equity

Fairness and equity are crucial values for public policy, and they are powerful ideas in public, political, and legal debates.[5, 8, 57] Fairness and equity also have a focal role in the context of universal health coverage (UHC).[31, 32, 40, 58, 59] Not only can they motivate the goal of UHC; they bear on the critical choices on the path to that goal. When UHC cannot be realized immediately, making progress fairly and equitably becomes imperative. More specifically, when countries expand priority services, include more people, and reduce out-of-pocket payments, they must seek to do so fairly and equitably.

Fairness and equity are fundamentally concerned with the distribution of benefits and burdens in society. There is no consensus on the precise boundaries of the concepts of fairness and equity or on their precise content. In this report, we use the two terms interchangeably. At the same time, a useful distinction between horizontal and vertical equity can be made. Horizontal equity requires equal treatment of relevantly similar cases, while vertical equity requires appropriately unequal treatment of dissimilar cases.[i] These standards can be applied to the distribution of health benefits and health service coverage and to the distribution of burdens, including financial contributions to the health system.

Beyond these general concerns, there may be widespread agreement on more specific issues. For example, many people find it unfair if some parts of the population do not have affordable access to even highly cost-effective services targeting very severe conditions, while other parts of the population are covered for very costly services that provide only limited benefits. Examples in the former category of services are antibiotics for pneumonia, skilled birth attendance, malaria treatment, and secondary prevention of stroke and myocardial infarction. An example in the latter category of services may be costly, experimental chemotherapy without proven benefits.

Benefit maximization

Alongside fairness, another cardinal objective of public policy is benefit maximization, that is, the maximization of total benefits across all people in society.[ii] With respect to

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[i] Horizontal and vertical equity have been discussed extensively in the context of health care as well as in many other settings.[60-62] The precise definitions used vary and sometimes depart from those used here.

[ii] This is sometimes framed in terms of efficiency. Strictly speaking, however, efficiency can be defined with reference to any objective, including fairness and equity objectives.

health, the relevant benefits can include, for example, additional life years or improvements in health-related quality of life. Although fairness is directly concerned with the distribution of benefits across people, the goal of benefit maximization is directly concerned only with the total sum of benefits. This goal often motivates a concern for cost-effectiveness, that is, a concern for the relation between the benefits generated and the resources used.

In many cases, the demands of fairness and benefit maximization go together. Among alternative policies, it is not uncommon that the policy which is most fair—under the relevant interpretation—also generates the greatest sum of benefits.[21, 63, 64] For example, WHO's "best buys" for maternal, neonatal, and child health services are likely to benefit those with the worst health and the poorest access to health care and, at the same time, maximize the sum of health benefits (compared to many other services).[65] Similarly, services targeting the poorest and most marginalized parts of the population can maximize health compared to those services that do not.[66] Obviously, it is crucial that countries manage to identify policies that are optimal both from the perspectives of fairness and benefit maximization when such policies exist. To do so, countries must pay close attention to evidence about total benefits as well as their distribution.

In other cases, the policy considered the most fair is not the one that maximizes benefits.[64,67-73] For example, treatment for hypertension may be more cost-effective than pneumococcal vaccine, while the vaccine targets conditions with a larger individual disease burden.[74] Similarly, fairness may recommend that coverage is extended first to a rural population that has lesser coverage, has worse health, and is poorer than an urban population.[75, 76] At the same time, the rural population may be more costly to reach with a given set of services, the services may be less effective in that population, or both.[63] The objective of benefit maximization may therefore give priority to the urban population. In situations where the two objectives diverge in what policies they recommend, it is, again, crucial that countries assess alternative policies with respect to both objectives. Only then can the objectives be carefully balanced and the best policy overall be identified. Such balancing acts are further addressed in subsequent chapters.

Guiding considerations

The objectives outlined above can motivate three more concrete guiding considerations for choices on the path to UHC:

- *Fair distribution*: Coverage and use of services should be based on need and priority should be given to the policies benefiting the worse off groups;
- *Cost-effectiveness*: Priority should be given to the most cost-effective policies;
- *Fair contribution*: Contributions to the health system should be based on ability to pay and not need.

These considerations are not absolute and must be balanced against each other as well as against other concerns.

Fair distribution

There are many reasons why coverage and use of services should be based on need.[iii] Several central reasons were described in chapter 1 and are related to the importance of health and health services to individuals and society, the right to health, and the collective responsibility for affordable access. In particular, no one should be denied coverage for high-priority services simply because he or she is poor and unable to pay.

More specifically, a fair expansion of coverage gives priority to policies benefiting the worse off. Individuals or groups can be badly off in different ways, and the many motivations for priority to the worse off partly refer to different aspects of their condition.[77, 78]

First, one may be concerned with the worse off in terms of health, socioeconomic status, or overall well-being. One motivation can be that the worse off so defined are at a lower absolute level and typically have a greater need for the benefits that comes with improved coverage.[79, 80] Another, related motivation can be the promotion of equality, including equality of opportunity.[5, 60, 81-84] Moreover, priority to the worse off can be motivated by the right to health.[85] In any case when considering the worse off in terms of health or well-being, there are good reasons to focus not merely on those *currently* worse off, but rather on the people who are expected to be worse off over their lifetime.[81, 86] This will be further discussed in subsequent chapters.

Second, one may be concerned about the worse off in terms of service coverage. Their coverage may be limited for all kinds of reasons, including limited availability of services, barriers to access to available services, and limited financial protection. Special attention to people with the least coverage can be motivated in many ways. For example, those with the least coverage are typically those in the greatest need of an improvement. Moreover, priority to people with the least coverage can promote equality in coverage and bring as many people as possible above a certain level of coverage. Partly through these effects, special attention to people with the least coverage can also be seen as mandated by the right to health.

Alternatively, one may be more directly concerned with the distribution of coverage than specifically the worse off. For example, certain distributions better express equal respect and equal human dignity than other distributions.[87] In addition, certain distributions of coverage can be motivated by their effects on the distribution of outcomes in terms of health or overall well-being.[5] For example, special attention to people with the least coverage may promote equality in these outcomes,[5] and priority to people with the least coverage can in many circumstances also maximize total benefits.[63, 66]

Cost-effectiveness

A fair and optimal expansion of coverage gives priority to cost-effective policies and services. These are the policies and services that generate large total benefits relative to cost. Many national and international guidelines emphasize cost-effectiveness.[19, 88] Priority to cost-effective policies is typically motivated by the goal to maximize health benefits, that is, to obtain as much benefit as possible from the available resources.[89-92]

[iii] These reasons will often tell against a "contribution principle," according to which people who contribute the most to the system should have priority in the distribution of benefits.

However, special attention to cost-effective policies and services can to some extent also be motivated by fairness.[iv]

Fair contribution

A fair expansion of coverage promotes the separation of use of services from payment for services. This is especially important for high-priority services. Use and payment of services can be decoupled by letting need guide the use of services while ability to pay primarily determines the required payments.[4, 35] Optimal separation of coverage and contribution requires a system that relies on mandatory prepayment and pooling of funds, as described in chapter 5.

The three guiding considerations can help identify critical issues of distribution on the path to UHC. The guiding considerations also provide direction for how these issues can be addressed and for fair progressive realization of UHC. However, the three considerations must always be balanced against each other as well as against other relevant concerns.

[iv] Differences in cost-effectiveness can be one among several differences that are relevant for fairness. However, the policy motivated *exclusively* by cost-effectiveness considerations can conflict with the policy recommended by the *overall* fairness judgment.

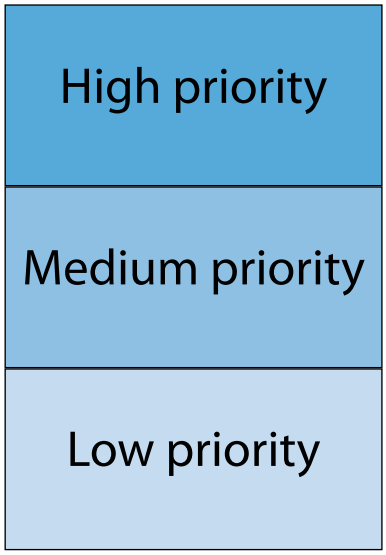
3 Expanding priority services

Universal health coverage (UHC) goes beyond a minimum package of health services and requires progressive expansion of a comprehensive range of key services. At each point on the path toward UHC, it is important to ensure an appropriate mix of services. To do so, countries must carefully set priorities and choose which services to expand next.

Whenever service coverage is expanded, priorities must be set among alternative services. When additional resources become available, countries are faced with a critical choice: Which services to expand first? Although no country starts from zero, and there is no single path to UHC that every country must follow, choices of this type continuously arise for all countries on the path to UHC. In fact every country continuously ranks alternative services, implicitly or explicitly. When choosing which services to expand first, it can be useful to sort services into at least three different classes: high-priority, medium-priority, and low-priority services. Such a simple scheme is illustrated by figure 3.1.

Broad classes like these can simplify the decision-making process. However, it must be acknowledged that the boundaries between classes will not always be straightforward and that there will be significant differences in importance also between services within each class.

Figure 3.1 Simple classification of services



For countries without universal coverage for all high-priority services, expanding coverage for these services should be the first priority. Coverage for low- or medium-priority services should generally not be expanded before there is near universal coverage for high-priority services. Similarly, universal coverage for low-priority services should generally not be sought before coverage for medium-priority services is fully expanded.

The ranking and classification of services should be based on clear and reasonable selection criteria. Some criteria have a strong general rationale and are likely to be

found relevant across a wide range of contexts. At the same time, the criteria must be sensitive to relevant local circumstances and be integrated with public accountability and participation mechanisms such as those described in chapter 7.

The scope of service selection

When selecting services, a broad range of services must be considered. Attention must certainly go beyond treatment and curative services to also include prevention, promotion, rehabilitation, and palliative care. Services for prevention and promotion must further go beyond personal services to include various population-based interventions.[3,4] When different types of services are funded from different budgets, mechanisms must be in place to ensure optimal allocation of resources across budgets. Irrespective of the type of services, UHC requires due consideration of all the most important causes of morbidity and mortality. This means not only that countries must firmly address communicable disease and the unfinished agenda of the Millennium Development Goals (MGDs). UHC also requires services to mount an effective response to noncommunicable diseases (NCDs)—including mental disorders—and injuries. If the response to these conditions is concentrated on the most important services, substantial progress can be made without losing sight of the persisting burden of communicable disease.[93]

Explicit service selection must not be misinterpreted as being wedded to vertical or disease-specific programs. To the contrary, explicit service selection can facilitate health system strengthening around a comprehensive and well-integrated set of key services. Moreover, the criteria for selecting services are relevant not only for the expansion of services when new resources become available. The same criteria can also inform the displacement of existing, less important services by more important services within a fixed budget. In addition, similar criteria can be useful for countries that want to devise an explicit list of included and excluded services. Many countries explicitly focus on a set of services that targets the entire population or the part that is likely to have the least coverage.[94-96] Irrespective of whether such a list is used, there are good reasons—including those related to democratic accountability, social learning, and the prevention of corruption—for any health system to be as explicit as possible about what services are included and excluded and about what criteria guide service selection.[97]

Service selection criteria

There is a range of candidate criteria for selecting priority services and the optimal mix of services. Several different, yet often overlapping criteria have been set forth in national guidelines for priority setting. Countries with particularly explicit criteria include Denmark, the Netherlands, New Zealand, Norway, Sweden, and the United Kingdom (UK),[88] while many other countries lack explicit criteria.[94] Common for all of the proposed criteria is that they can be seen as primarily derived from two pairs of health system objectives: to improve population health and access to services and to distribute health and health services fairly. Several sets of relevant or potentially relevant criteria have also been proposed in the academic literature,[70, 98-100] and several international initiatives have been concerned with criteria for service selection.[19] One criterion often emphasized is the cost-effectiveness criterion.

Priority to cost-effective services

One primary objective of health systems is to improve the health of the population. The cost-effectiveness criterion is about improving health as much as possible, and cost-effectiveness as a central guiding consideration was described in chapter 2. In the context of health systems, it is standard to define the effectiveness of a service in terms of the total health improvement in the population. However, because different services may require vastly different resources to be implemented, effectiveness on its own is not a sensible way to select services. It is better to consider cost-effectiveness, where benefits are normalized by their costs. Prioritizing services in order of their cost-effectiveness is usually the way to provide the largest possible sum of health benefits for a given budget. A more efficient system can meet more health needs per dollar spent, and this is of ethical concern and not simply an economic notion. Accordingly, an emphasis on cost-effectiveness needs not be motivated by overall cost savings—an this emphasis needs not even imply cost reduction—and can be solely motivated by the goal of improving population health.

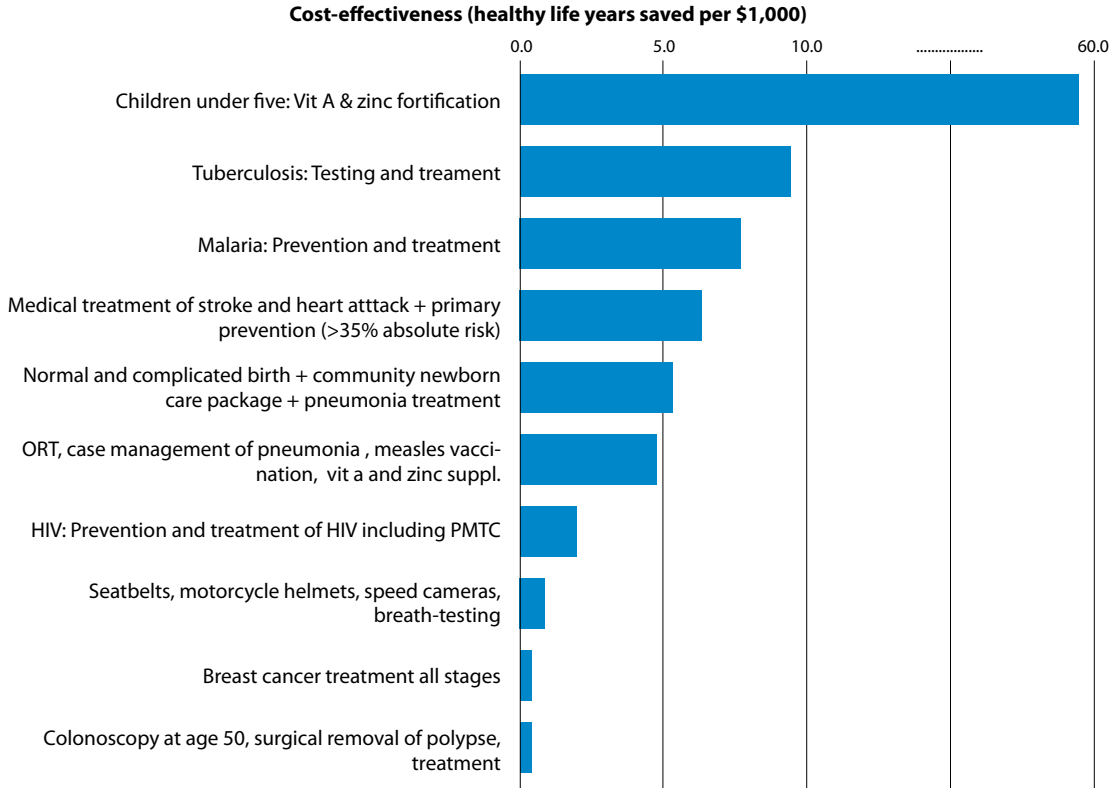
To use a cost-effectiveness criterion, a measure of health benefits is needed.[i] A common measure is the number of lives saved. However, one can never really save someone's life because an individual will always die at some later point. What matters is how much the individual's life can be extended. A better measure is therefore the number of life years saved. This still has the problem that it doesn't take into account the quality of these years at all, and it doesn't take into account services that improve life without extending it. Many health economists and ethicists therefore support a method of counting life years weighted by the quality of those years. For example, if a service provides an extra year of life at full health, the service is said to produce the same number of healthy life years as a service that improves two years of life from half quality to full quality. Healthy life years saved as a measure of effectiveness is closely related to two other commonly used measures: quality-adjusted life years (QALYs) saved and disability-adjusted life years (DALYs) averted.[101, 102]

Healthy life years is not a perfect measure of health benefits, but it can nevertheless be very useful in comparing all types of health services. Moreover, the difference between health services are often so great that even an imperfect measure is highly valuable.[103, 104] This is illustrated by the WHO-CHOICE data in figure 3.2, which includes a selection of services targeting high-burden conditions. As is shown in that figure, according to WHO estimates, some interventions are extremely cost-effective. Fortification of foods with vitamin A and zinc can avert the loss of almost 60 healthy life years per $1,000 spent. If the same amount were spent on dialysis (not shown in the graph as dialysis has not yet been included in WHO-CHOICE analysis), it would save just 0.02 healthy life years—losing 99.97 percent of the total health benefit that could have been produced.[105] Taking cost-effectiveness into account is thus extremely important. Other services listed in figure 3.2 are also highly cost-effective, such as testing and treatment for tuberculosis, prevention and treatment of malaria, and primary prevention (for very-high-risk individuals) and treatment of myocardial infarction and stroke. Data on cost-effectiveness are now becoming increasingly available, for example, through the WHO-CHOICE project, the Disease Control Priorities (DCP) project, and initiatives in

[i] Sometimes, one would like to go beyond health benefits. The resulting type of analysis may be called extended cost-effectiveness analysis (ECEA) or, when the benefits are monetized, cost-benefit analysis (CBA).

high-income countries such as the National Institute for Health and Care Excellence (NICE) in the United Kingdom (UK).[103, 104, 106]

Figure 3.2 Cost-effectiveness of services targeting high-burden conditions



Estimates from WHO-CHOICE. $: International US dollars for year 2005. Observe that the x-axis is compressed.

Many national and international initiatives have suggested that health services should be prioritized primarily based on cost-effectiveness. Among the international initiatives are the 2001 Commission on Macroeconomics and Health[19] and the 2009 Taskforce on Innovative International Financing for Health Systems.[107] Many economists and ethicists also support emphasizing cost-effectiveness and find it unethical to ignore opportunity costs and the size of health benefits.[89, 91, 108] If a health system covers services that are not cost-effective while people are dying from diseases that can be treated cheaply and effectively, that will in most circumstances be unfair.

In practice, generating and using cost-effectiveness data can be challenging. However, as noted, such data are increasingly available,[103, 104] and several practical guidelines and tools now exist.[92, 103] Moreover, even an imperfect application of the cost-effectiveness criterion—combined with other relevant criteria—is likely to be better than ignoring cost-effectiveness entirely, as suggested by the huge variation in cost-effectiveness across services.

Priority to services benefiting the worse off

An exclusive focus on cost-effectiveness is generally found indefensible. Standard cost-effectiveness analysis is concerned solely with the total number of healthy life years. This analysis thus counts every additional healthy life year as equally important, no matter whether the additional benefit would accrue to a person with very bad health or to someone with only a small reduction in health. Fairness, however, suggests that

providing a health improvement of a fixed size to someone who (without it) would have less health takes priority over providing that health improvement to someone who would have more health. In other words, fairness recommends priority to services benefiting the worse off.

Surveys suggest that the judgment that the worse off should receive some priority is broadly shared across societies.[109-112] Priority to the worse off—as one among other criteria—also has a firm grounding in the theory of fair distribution.[5, 71, 79-81, 113] As for policy, priority to the worse off—often with reference to "need," "severity," or "urgency"—has also figured centrally in many national guidelines on priority setting, including those in the Netherlands, Norway, and Sweden.[88, 114]

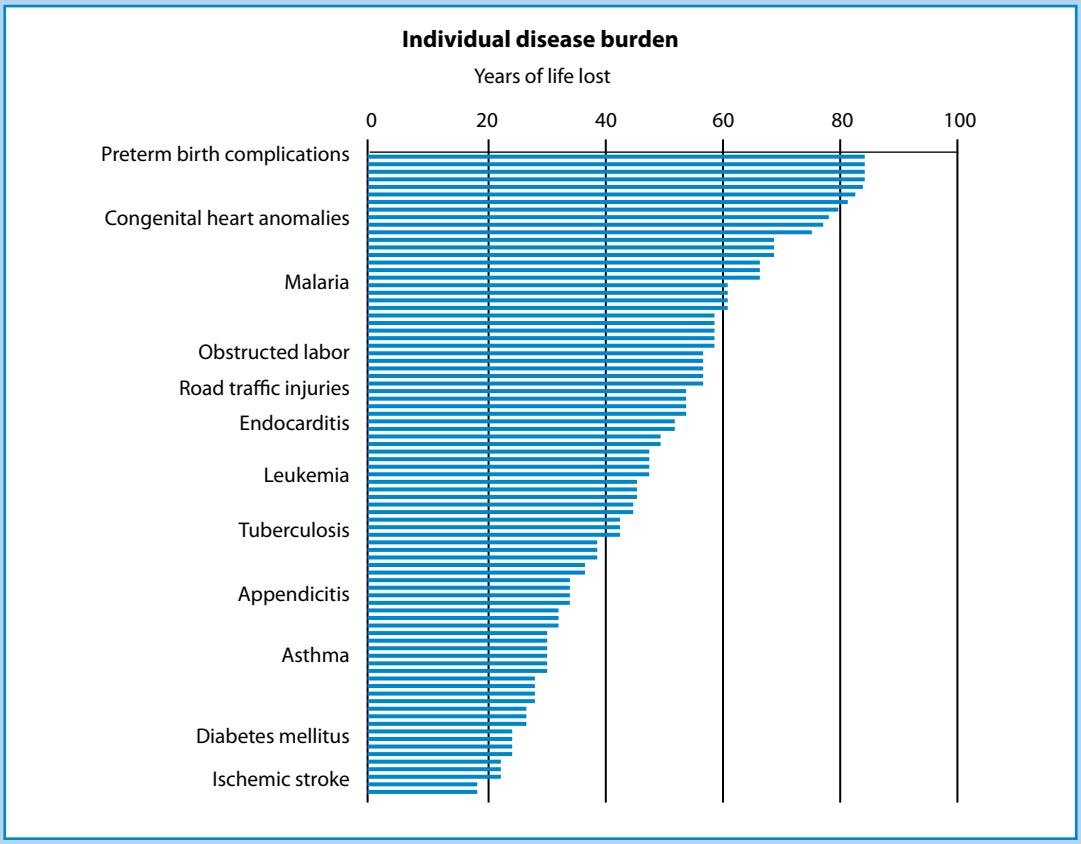
Although it is not only health that matters, the worse off in terms of health are generally central to health policy. The worse off in terms of health are also a natural starting point as available data allow for a reasonably precise characterization of the worse off in that respect. When focusing on health, however, it is important to focus not only on those that *currently* have the worst health. Indeed, there are good reasons to start with those worse off over their *lifetime*. There is both empirical and theoretical support for why one should focus on those worse off thus understood, rather than those worse off here and now or the worse off only prospectively.[81, 86, 111, 112] Consider, for example, the following two services. One service somewhat improves the sight of an adult who lost his or her sight at a young age. Another service cures the moderate mobility impairment of a different adult, who otherwise has good health for a normal lifespan. Suppose the services are equally costly and yield the same health gain but that the blind adult has lower lifetime health without the service than the person with the moderate mobility impairment. Other things being equal, it seems unfair if the service for the blind adult was not accessible at an affordable cost before the service for the mobility-impaired adult.

To aid service selection, a measure of the lifetime worse off can be useful. One possibility is to specify the worse off as those with the largest individual burden of disease. More specifically, the worse off can be defined as those with the largest individual lifetime disease burden without the health service in question. In contrast to the national burden of disease, individual disease burden is not aggregated across people and can therefore provide direct information about the burden placed on individuals. There are several possible ways to calculate individual burden of disease, and one is described in box 3.1. The figure in that box also indicates the individual disease burden for a range of conditions.

Box 3.1 Calculation of individual burden of disease

The individual burden of disease can be estimated in several ways. In the following figure, the estimation is simplified by considering only life years lost, not healthy life years lost. Mortality data for Eastern sub-Saharan Africa from the Global Burden of Disease 2010 Study are used.[101] The total number of years of life lost due to a certain disease in the region is divided by the number of deaths from that disease. Years of life lost thus represent the average years of life lost for those for which the condition is fatal. Accordingly, age of death drives the estimation of individual disease burden. The estimation of years of life lost in the Global Burden of Disease 2010 Study is based on a reference life table with life expectancy at birth of 86 years. For country analyses, national life tables could be used.

Ranking of conditions according to individual disease burden



All the conditions shown in the figure are associated with a large individual disease burden. Many conditions associated with a much smaller burden are not shown.

As is evident from box 3.1, the individual disease burden associated with different conditions varies substantially. Individuals about to die from a condition associated with a very large individual disease burden, such as congenital heart anomalies and malaria, are generally worse off (in terms of the number of healthy life years enjoyed during their lives) than individuals about to die from conditions associated with a smaller individual disease burden, such as ischemic stroke. Similarly, individuals about to die from ischemic stroke are generally worse off than people with conditions that are associated with a smaller burden. Priority to services benefiting the worse off thus characterized captures a widely held idea of fairness, as described. According to this idea, a healthy life year benefiting someone who otherwise would have few such years over his or her lifetime has more weight than a healthy life year benefiting someone who would have many. How much weight remains to be decided in each country,

and some qualify the general rule by exempting very young children.[99, 115] In any case, average estimates for conditions—including the estimates for individual burden of disease in box 3.1—are primarily relevant at the health program level, as opposed to the individual level.

As noted, considering the worse off in terms of aspects other than health can also be relevant. In particular, health systems could consider special priority to services targeting conditions that disproportionally affect the poor. This is indeed the central component of one of two "progressive pathways" proposed by the Lancet Commission on Investing in Health.[21] A criterion giving priority to services benefiting the worse off—broadly understood—can accommodate such an approach. An alternative strategy is to select services primarily based on health-focused criteria and then give the poor priority when expanding coverage for these services. Elements of the two strategies can be combined, and the question of whom to give priority when expanding coverage is further discussed in chapter 4.

Priority to services whose coverage offers substantial financial risk protection

Financial risk protection is a key rationale for pursuing UHC. As discussed in chapter 5, large out-of-pocket payments for health services can cause severe financial strain on a patient and his or her family, and in numerous countries, the proportion of health service costs paid out-of-pocket is very high. General reduction in out-of-pocket payments is therefore critical for progress toward UHC. However, financial risk protection can also be relevant for the selection of services. Accordingly, one may apply a criterion that suggests that a service should have priority to the extent that coverage of the service offers substantial financial risk protection.[ii]

Expanding coverage for a given service can provide financial risk protection directly as well as indirectly. In the former case, coverage provides protection against financial burdens linked to payment for the service in question. In the latter case, coverage provides protection against the wider financial burdens that go beyond the service in question. These burdens include loss of earnings due to an inability to work and medical expenses for other services in the future.

Several factors increase the amount of direct protection associated with coverage of a particular service. These factors include high cost and out-of-pocket payments, low predictability of need, pronounced urgency and severity of the target condition, and high incidence of the target condition among the poor.[62, 116-118]

Against this background, it is clear that cost may have a complex role in service selection. Coverage of a high-cost service can in many cases reduce direct financial hardship more than coverage of a low-cost service. At the same time, high cost will, other things being equal, imply a higher cost-effectiveness ratio with respect to health benefits. Accordingly, there may be a conflict between cost-effectiveness and direct financial risk protection. However, it need not be that way. Especially in resource-poor settings,

[ii] Economic modeling has shown that if no one buys complementary services beyond a mandatory package of services or if well-functioning complementary insurance exists, then service selection based on standard cost-effectiveness ratios would tend to maximize expected welfare.[116] In low- and middle-income countries, however, there are substantial out-of-pocket payments for complementary services and no well-functioning insurance of that kind. In such situations, financial risk protection may become more relevant to the selection of services.

even out-of-pocket payments related to low-cost services may be a significant cause of financial hardship and financial catastrophe. In such settings, expanding coverage for low-cost services may actually also be the most efficient way of purchasing direct financial risk protection.[21]

It has been suggested that for two services with identical cost-effectiveness ratios, the most costly service should typically be covered first, because this approach offers a greater degree of direct financial risk protection.[116, 117] However, this has to be balanced against the aggregate financial risk protection that could come with coverage of a larger number of less costly services. Moreover, when cost-effectiveness ratios differ, the direct financial benefits must be carefully balanced against the health benefits.

In box 3.2, some possible trade-offs of this kind and how these can be addressed are described. The analysis in the box also includes a form of indirect financial risk protection, namely, protection from large out-of-pocket payments for certain services in the future due to reduced risk of need for these services.

Box 3.2 Trade-offs between health benefits and financial benefits

The figure below shows the results of an analysis of nine services. The figure indicates how much of each type of benefit that would be produced if we spent $100,000 on each listed service. A service yields greater health benefit the further to the right it is and more financial protection the further toward the top it is. The findings demonstrate how the aim of averting deaths and the aim of averting poverty can conflict.[iii] For example, the meningococcal (MCV) vaccine averts more than 300 deaths per $100,000 spent but averts few poverty cases. In contrast, high blood pressure treatment averts fewer deaths but many more cases of poverty.

Health & financial risk protection benefits afforded, per $100,000 spent

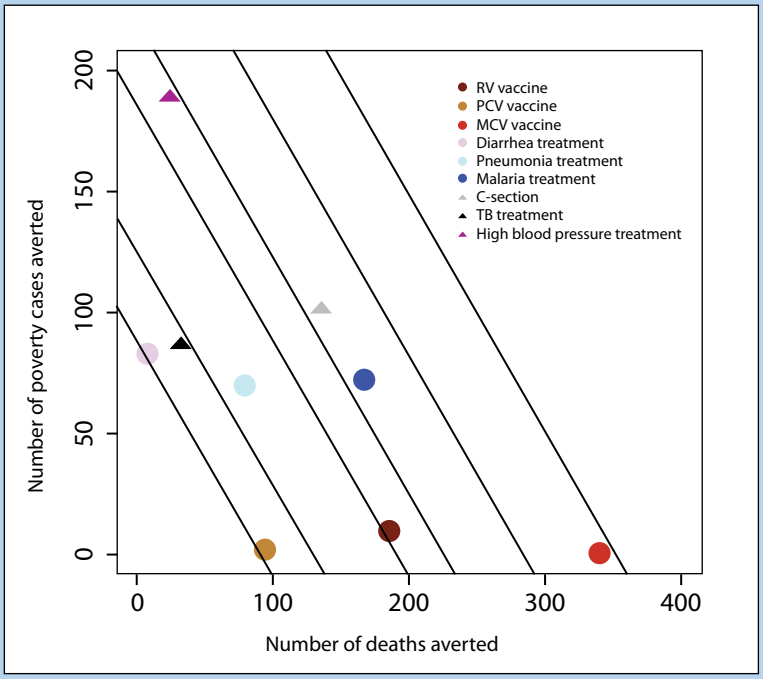


Figure adapted from Jamison et al. 2013.[21] Indifference curves added.

Decision makers may disagree on exactly how to trade off lives saved against cases of poverty averted, but one can imagine drawing diagonal contour lines in the diagram that connect points that are equally good overall (known as "indifference curves" in economics). For a given individual, it is plausibly worse to die than to become impoverished, and this suggests that the contour lines should be at least as steep as those shown in the figure.

As indicated, even though financial risk protection is very important, one must be careful not to give too much weight to direct financial risk protection when selecting services. This is mainly because this approach may involve large sacrifices in terms of health benefits. This is unfortunate due to the intrinsic value of health benefits, but it can also be unfortunate from the perspective of financial risk protection. One reason is that the health benefits may reduce the risk for certain health expenditures in the future, as discussed. In addition, health benefits may provide financial risk protection through improved productivity and income-earning potential.[19, 21]

Against this background, some services are so costly that they should probably not be included among high-priority services in resource-poor settings. To illustrate, consider some very costly treatments with marginal health benefits for patients with certain types of advanced cancer.[119-123] Even if coverage for these services may offer significant direct financial risk protection for the patient and his or her family, the resources spent could—in some contexts—instead save 100 to 300 times as many years of healthy life if spent on treatment for pneumonia or on tuberculosis control. As described, these health benefits can also offer considerable financial risk protection at a later date. Therefore, when selecting services, all these conflicting concerns must be carefully balanced. Tools are currently being developed to assist in such balancing tasks.[124, 125]

Irrespective of the role that financial risk protection may have in *service selection*, financial risk protection has a crucial role in motivating the very goal of UHC and the *general shift* from out-of-pocket payment to mandatory prepayment. The latter role and this general shift are further discussed in chapter 5.

Additional criteria

Several other criteria for priority setting may be relevant.[99] Many of these overlap with the criteria already outlined and some can even be integral to those criteria. Quality of services, for example, is a key concern in the pursuit of UHC and may not be fully captured in cost-effectiveness estimates. To that extent, an additional criterion related to quality may be needed. Likewise, a criterion related to strength of evidence may be needed if that concern is not sufficiently taken into account by the other criteria.

Building on a consensus statement developed by a group of ethicists and economists, at least ten priority-setting criteria could be *considered* in conjunction with cost-effectiveness.[108] Several of these criteria are concerned with fairness and equity and overlap with the criteria outlined or with concerns addressed in subsequent chapters. The criteria may or may not be relevant for specific decisions about services. Moreover, the actual use of some of the criteria is controversial, and most ethicists would contest some of them. The proposed additional criteria fall into three categories: (a) disease and service criteria, (b) criteria related to characteristics of social groups, and (c) criteria

[iii] The study did not report healthy life years averted, only deaths averted.

related to protection against the financial and social effects of ill health and costly treatment. The specific criteria are listed in box 3.3.

Box 3.3 Additional criteria that may or may not be relevant

Disease and service criteria: Criteria related to
• severity of disease (present and future health gap);
• realization of potential;
• past health loss.
Criteria related to characteristics of social groups: Criteria related to
• socioeconomic status;
• area of living;
• gender;
• race, ethnicity, religion, and sexual orientation.
Criteria related to protection against the financial and social effects of ill health and costly treatment. Criteria related to
• economic productivity;
• care for others;
• catastrophic health expenditures.
Based on Norheim et al. 2014[108]

It is also important to keep in mind that some concerns are not easily quantified or included in standard frameworks. Concerns of this type include those related to domestic violence against women, palliative and terminal care, social care, infertility, and abortion.

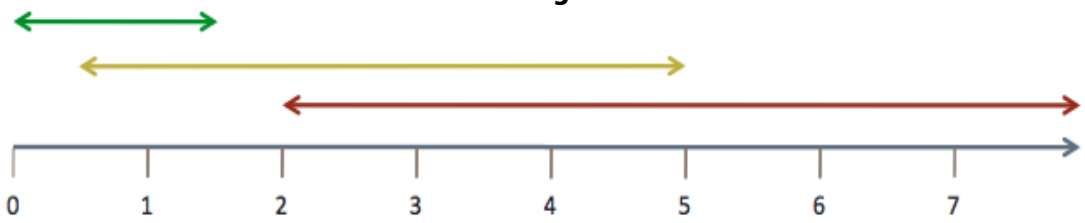
Combining criteria

Overall, at least three criteria should be considered in service selection. These criteria are those related to cost-effectiveness, priority to the worse off, and financial risk protection.

Decision makers can use different strategies when addressing a set of criteria. Since improving health is a primary purpose of the alternative health system, one useful strategy is to start with cost-effectiveness data to roughly sort services into priority classes and then make adjustments based on additional criteria. Figure 3.3 illustrates one schematic way in which this can be done. In that figure, the cost of a healthy life year is described in fractions or multiples of gross domestic product (GDP) per capita. While the thresholds linked to different priority classes plausibly vary somewhat with GDP per capita, this is not to suggest that there is one fixed share of GDP relevant for all countries. More importantly, the exact cut-offs between classes in the figure are just for illustration and need to be determined by each country.[iv]

[iv] The relevance of context is even more evident when cost-effectiveness thresholds are meant to apply more directly to the decision about whether a service should be covered or not.[126, 127]

Figure 3.3 Framework for integrating cost-effectiveness with other criteria when selecting services

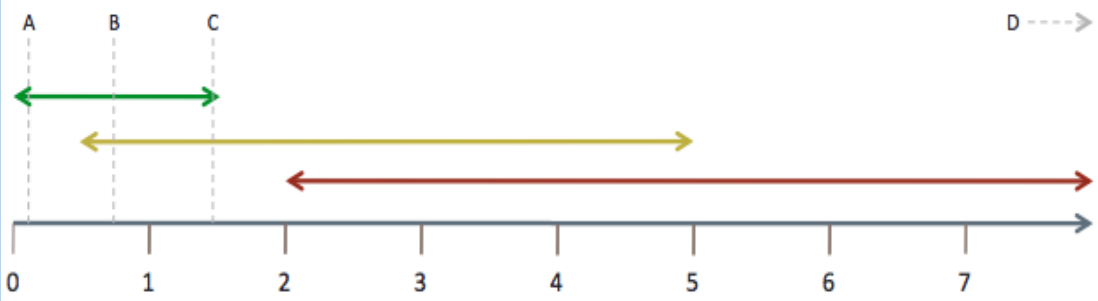


Cost per healthy life year as a multiple of GDP per capita

To determine which services to expand next within this framework, a country first generates a list of services being considered. Each service can then be put on this scale according to regional or national cost-effectiveness estimates. Services associated with only one color are immediately placed in the relevant priority class. Each service located in the overlapping intervals needs further assessment against other relevant criteria, for example, those related to priority to the worse off and financial risk protection. If the service clearly fares well against the additional criteria, it should be placed in the higher priority class in question. If the service clearly fares badly against those criteria, it should be placed in the lower priority class in question. The exact location of a service within overlapping intervals should also be taken into account. The closer to the cost-effective end of that region, the less an additional reason is needed. Box 3.4 provides a practical example of how the framework presented here can be used.

Box 3.4 Application of framework to hypothetical cases in Kenya

The practical use of the framework can be illustrated by applying it to hypothetical cases in Kenya. Using regional cost-effectiveness data and national income data, four services (A, B, C, D) have been placed on the scale.*



Cost per healthy life year as a multiple of GDP per capita

If the cut-off values along the scale were to be the relevant ones, the decision maker could reason as follows:

A: *Tuberculosis diagnosis and treatment*

Costing less than 10 percent of GDP per capita per healthy life year, this is clearly in the green category and thus a high-priority service.

B: *Traffic safety regulation*

At a cost of 80 percent of GDP per capita per healthy life year, this falls in the region where green and yellow overlap, requiring further assessment against additional criteria. Priority to the worse off is especially relevant here as traffic accidents often cut down people in their youth (see box 3.1). We would therefore expect the service to be placed in the high-priority category.

C: *Treatment for mild asthma*

Costing 149 percent of GDP per capita per healthy life year, treatment for mild asthma is only just within the overlap region and would need to fare extremely well on the additional criteria in order to be placed in the high-priority category. We would therefore expect the service to be placed in the medium-priority category.

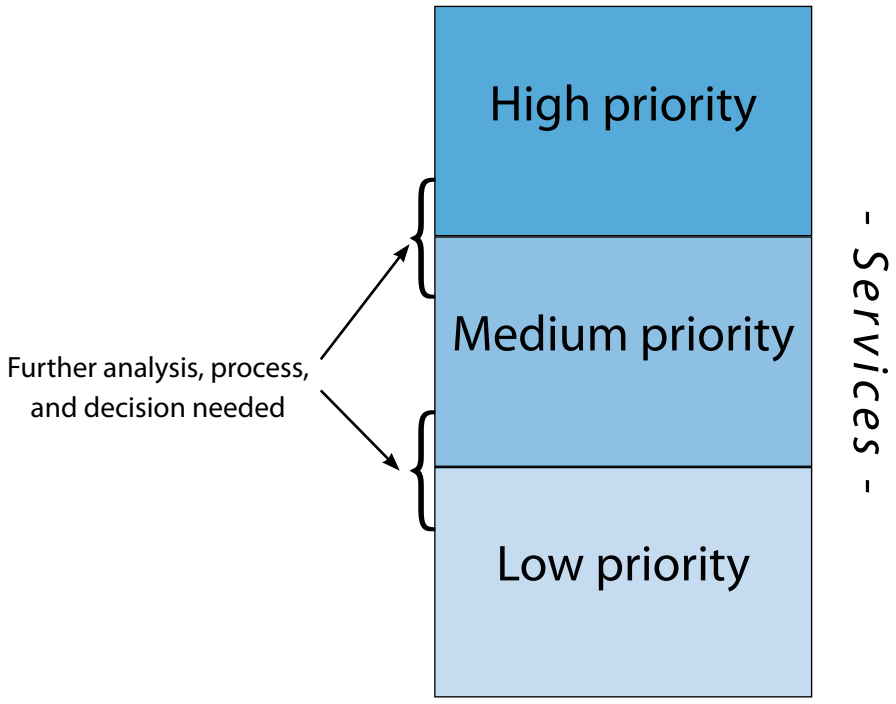
D: *Dialysis for renal failure*

Even though coverage offers significant financial risk protection, dialysis is far too expensive in this setting, costing more than 30 times the GDP per capita per healthy life year. Dialysis is therefore placed in the low-priority category. Money spent on dialysis could instead save 300 times as many healthy life years if spent on tuberculosis control.

** Cost-effectiveness estimates are based on the WHO-CHOICE project and a study on dialysis in Thailand* [103, 105]

In some cases, applying the relevant criteria—even when appropriately specified by the country—will not unambiguously assign all the service in question to a single priority class. For services located at the border between two classes, an appropriate decision-making body may make the final decision based on a more meticulous, overall assessment. This could be a standing committee for priority setting, whose one potential role would be to decide on hard borderline cases, as illustrated in figure 3.4. Such committees are now established in some countries and are further discussed in chapter 7.

Figure 3.4 Potential role of standing committee for priority setting in service selection



As suggested, the health system should first expand coverage for the service in the highest priority class. If one has to choose between two or more services in the same class, a similar procedure can be used to choose between them. At the same time, service selection must be seen as a dynamic, continuous process. The patterns of disease and service coverage continuously change as do, for example, estimates of costs and effectiveness. To improve the service selection process, countries should therefore build and strengthen institutions that can generate and use such information.

Importantly, the procedure outlined here is only a general framework for integrating cost-effectiveness with other criteria. The use of such a framework is an improvement

at least over unsystematic service selection. The framework can also accommodate methods for explicit, precise weighing of specific criteria. Several methods of this kind have been developed to integrate cost-effectiveness with other concerns, including concerns for fairness.[67, 128] Among these methods is the use of so-called equity or distributive weights that, for example, can incorporate special priority to the worse off. As noted, methods are also being developed to incorporate financial risk protection.[124]

Conclusion

Careful selection of services is crucial for fair progressive realization of UHC. Many countries select services *ad hoc* and only with the use of implicit criteria. Instead, the process of expanding services should be systematic and based on explicit, well-founded criteria. Relevant criteria include those related to:

- cost-effectiveness;
- priority to the worse off;
- financial risk protection.

All criteria must be specified and balanced in a way that is sensitive to country context. To this end, robust public accountability and public participation are essential. This is further discussed in chapter 7.

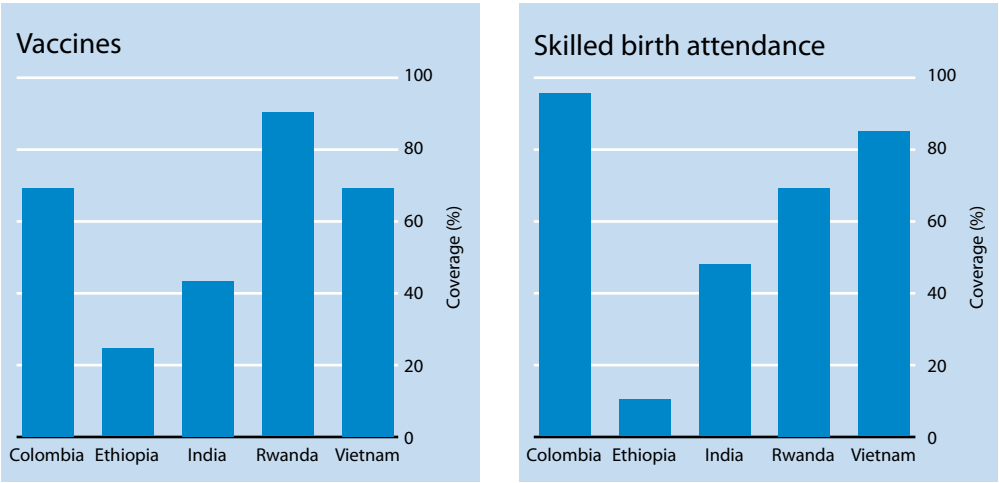
4 Including more people

The goal of universal health coverage (UHC) gives clear direction for the scope of coverage: it should be universal. Countries must seek to reduce all barriers to coverage, for everyone. When coverage cannot be fully extended to everyone immediately, countries are faced with a critical choice: Whom to include first?

The challenge of coverage gaps

Coverage for specific services varies substantially across services and across countries. This can be illustrated by coverage indicators that measure how many individuals receive a health service if they need it.[i] With coverage thus understood, there are numerous examples of coverage falling far short of universality, even for high-priority services. For example, in Ethiopia, the proportion of children under five years with diarrhea who receive at least oral rehydration therapy or advice about increased fluids is about 30 percent, the proportion of children under five years with suspected pneumonia who are taken to an appropriate care provider is below 10 percent, and the proportion of live births attended by skilled health personnel is 10 percent.[130] Coverage rates for two key services in five countries are illustrated in figure 4.1.

Figure 4.1 Coverage rates for two key services in five countries[ii] [iii]



[i] Such measures are useful even though they do not fully capture the extent to which services are affordable. These indicators, often also called utilization rates, do not distinguish between people who have access without significant out-of-pocket expenditures and people who have access despite facing such expenditures.[129]

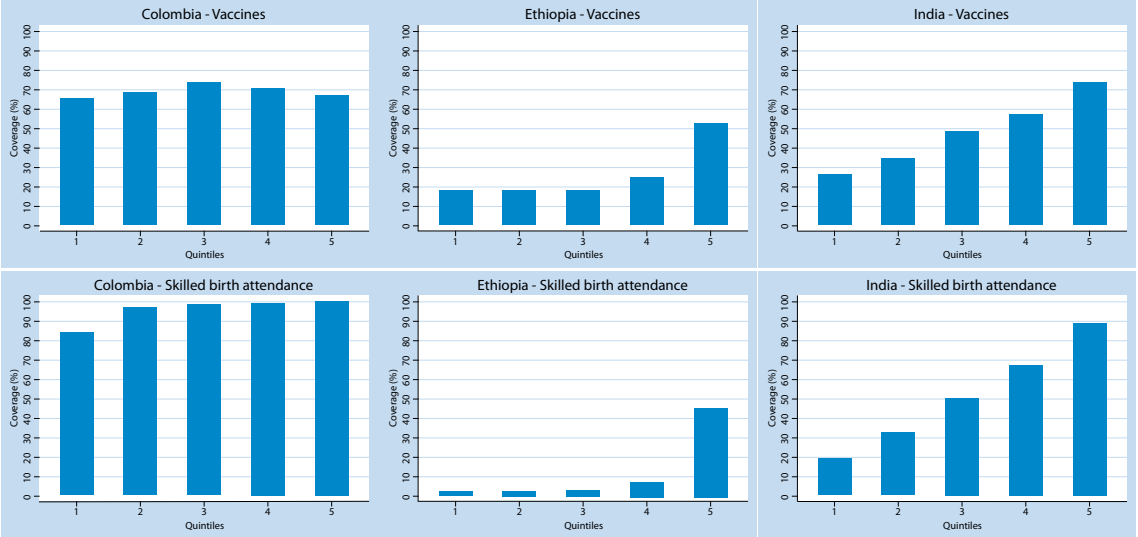
[ii] Skilled birth attendance coverage is defined as the proportion of women reporting being assisted by a health professional during delivery. Vaccination coverage is defined as the proportion of children aged 12 to 23 months who at the time of the survey had received the following vaccines: three doses of diphtheria-tetanus-pertussis (DTP), three doses of polio, BCG, and measles.

[iii] Data on Colombia, India, Rwanda, and Vietnam are from the World Bank,[131] while data on Ethiopia are from the Ethiopia Demographic and Health Survey (EDHS) 2011.[130]

In addition to the general level of coverage, distribution is important. It is well documented that different groups in society have unequal probabilities of receiving a given health service if they need it.[132] More specifically, this tends to be the case with groups categorized according to socioeconomic status (income, wealth, occupation, education), gender, area of living, and health status and sometimes ethnicity, race, religion, and sexual orientation.

Regarding socioeconomic status, skilled birth attendance in Ethiopia provides one clear example of a social gradient. In the lowest wealth quintile, 1.7 percent of all births are attended by a skilled provider, as opposed to 45.6 percent in the highest wealth quintile.[130] This inequality is an example of horizontal inequity, which was discussed in chapter 2. Inequalities in coverage rates, across wealth quintiles, for two key services in Ethiopia, India, and Colombia are shown in figure 4.2. From the figure, we see that Ethiopia and Colombia generally have the most and the least pronounced inequalities, respectively. Social gradients in effective health care and health outcomes are also found in the context of noncommunicable diseases.[133]

Figure 4.2 Socioeconomic inequalities in coverage rates in three countries[iv]



In many countries, there are also marked geographic variations, across regions and between urban and rural settings. Inequalities in coverage rates for skilled birth attendance across the urban–rural divide in Colombia, Ethiopia, and India are shown in figure 4.3. Again, skilled birth attendance in Ethiopia provides one clear example of geographic inequality. In the urban population, 50.8 percent of all births are attended by a skilled provider, while in the rural population, the proportion is 4.0 percent.[130]

Another challenging inequality is that between genders. Data on coverage across the gender divide in low- and middle-income countries are scarce. However, figure 4.4 shows gender inequality in under-five mortality in Colombia, Ethiopia, and the rural and urban populations in India. Although inequalities in health outcomes partly depend on factors other than coverage, countries must also be sensitive to such inequalities when expanding coverage.

[iv] Data on India and Colombia are from the World Bank,[131] while data on Ethiopia are from the Ethiopia Demographic and Health Survey (EDHS) 2011.[130]

Figure 4.3 Geographic inequalities in coverage rates for skilled birth attendance in three countries[v]

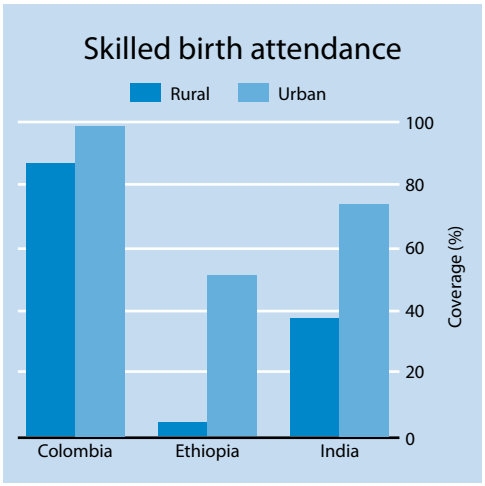
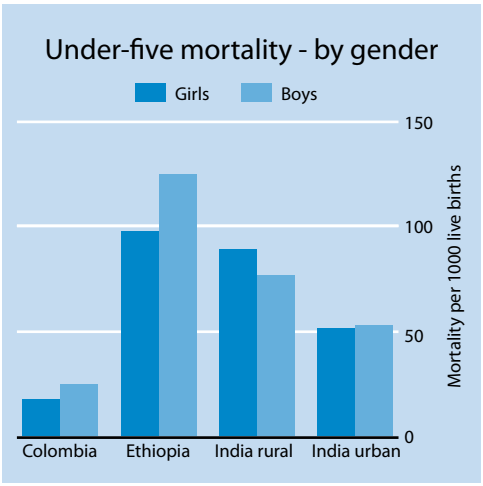


Figure 4.4 Gender inequalities in under-five mortality in three countries[vi]



Most, if not all, of the inequalities outlined represent inequities under most interpretations of inequity, as discussed in the preceding chapters. For example, these inequalities are generally considered unacceptable within a right to health framework, especially when they result from discriminatory practices.[136]

In many countries, there are also numerous indications of the "inverse care law," according to which "the availability of good medical care tends to vary inversely with the need of the population served."[137] Patterns compatible with this "law" are commonly found, for example, with respect to the groups already discussed.[66] As described, coverage is often more limited for low-income groups and rural populations than for higher income groups and urban populations, although the need for services is often greater among these groups, as suggested by, among other things, well-documented inequalities in mortality and morbidity.[40] In particular, in countries at all levels of income, health and illness follow a social gradient: the lower the socioeco-

[v] Data on Colombia, India, Rwanda, and Vietnam are from the World Bank,[131] while data on Ethiopia are from the Ethiopia Demographic and Health Survey (EDHS) 2011.[130]

[vi] Mortality rates are calculated from the Colombia Demographic and Health Survey 2010,[134] the Ethiopia Demographic and Health Survey 2011,[130] and the India Demographic and Health Survey 2005-06.[135] While the figures for India are based on the five years preceding the survey, the other figures are based on a ten-year period.

nomic position, the worse the health. In most cases, the resulting mismatch between need and coverage is doubly problematic and incompatible with widely held views on fairness and equity.[138]

Whom to include first

It is evident that coverage is far from universal in many countries. If coverage cannot be extended to everybody immediately, countries that want to move toward universality face a critical choice: Whom to include first? To "include" here means to expand coverage up to a significant level, and this typically presupposes formal affiliation with a coverage scheme.

The considerations emphasized in the preceding chapters and the inequalities described above provide guidance. In chapter 2 and 3, it was suggested that a fair expansion of coverage involves giving priority to the worse off. As indicated, this is particularly the case for the worse off in terms of service coverage or health. Accordingly, in most circumstances, countries should first reduce barriers to coverage for groups that are disadvantaged in terms of service coverage or health.

Identifying these groups directly is often difficult. However, as illustrated above, certain more easily identifiable, social groups tend to have poor service coverage, poor health, or both. These groups include, for example, low-income groups and rural populations. A more extensive list of potentially relevant social characteristics is shown in box 4.1. In addition, health state and prognosis are, of course, associated with many medical characteristics (including diagnosis and risk factor exposure), something which was discussed in chapter 3.

Box 4.1 Social characteristics often associated with service coverage or health

There are several social characteristics that is often associated with service coverage, health, or both:

- Income/wealth
- Education
- Occupation
- Ethnicity/race/indigeneity
- Gender
- Area of living
- Refugee/immigrant status
- Religious and political beliefs
- Sexual orientation

This list builds on a framework of the Commission on Social Determinants of Health, linking social determinants of health and the distribution of health.[40]

How a given social characteristic is associated with being worse off can vary with context. For example, how ethnicity/race and religious and political beliefs are associated with health coverage and health often depend on the national and local setting. This can also be the case for urban and rural populations. For other characteristics, however, there is little variation across contexts. For example, the income group that is worst off in terms of service coverage and health tends to be the one with the lowest income.

The reasons for being concerned with the social characteristics listed may go beyond their role as indicators of service coverage or health. For one thing, the characteristics may be non-health components of well-being or indicators of such components. For example, low-income groups tend to be worse off than high-income groups not only because the former typically have worse service coverage and worse health than the latter, but also because low-income groups can also be seen as worse off simply by having lower income.[139] However, there is also another reason for being concerned with the listed social characteristics in a way that goes beyond their role as indicators of service coverage and health. For some characteristics, their association with service coverage or health often indicates problematic social practices and associated vulnerabilities.[140] For example, poor service coverage among women, relative to men, may suggest discriminatory practices in the finance and delivery of health services.

Overall, when expanding coverage, countries should strive to reduce barriers for low-income groups, rural populations, and other relevant groups to the extent that they are disadvantaged in terms of service coverage or health. This is especially important for high-priority services. At the same time, the various considerations of fairness must be carefully balanced against the concern for benefit maximization. This was discussed in chapter 2 and is further discussed below.

The role of targeting

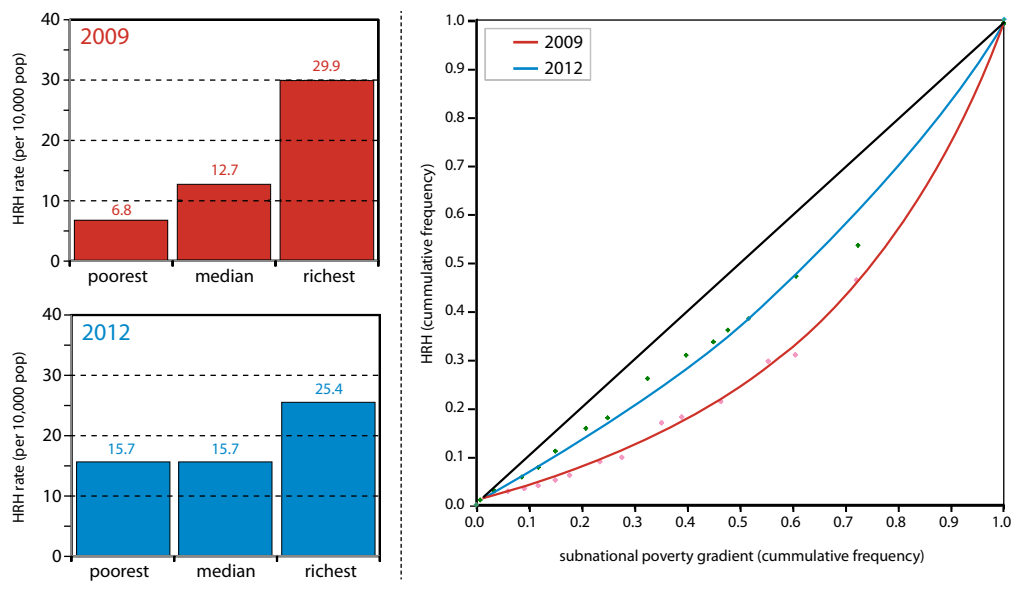
As described, fairness considerations motivate special attention to certain groups when expanding coverage. These include low-income groups, rural populations, and other relevant groups to the extent that they are disadvantaged in terms of service coverage or health. At the fundamental level, these groups should be targeted in the sense that improvements accruing to them should have some extra weight in policy formulation.

This may further motivate targeting at the practical level, if it can be done effectively. Many forms of targeting can be useful instruments for moving toward UHC and are

not in opposition to the goal of universalism in terms of overall coverage. However, the appropriate forms of targeting at the practical level is an ongoing debate within the health sector as well as more broadly,[21, 141-143] and most frequently discussed in the context of pro-poor policies. Although countries should, if possible, first reduce barriers to coverage for relevantly disadvantaged groups, the appropriateness of such a selective approach depends on the type of targeting and the context in which targeting is applied.

Practical approaches to targeting can be categorized in multiple ways. The most promising policies are probably those targeting groups, not individuals. One can further distinguish between approaches that identify the target group directly and those that do so indirectly, for instance, by area of living.[144] In the latter case, the initial effort to reduce one or more barriers to coverage can be concentrated in a specific geographic area. An example of such an approach is described in box 4.2.

Box 4.2 Geographic targeting for universal health coverage in El Salvador



In 2009, the Ministry of Health of El Salvador initiated a health sector reform aimed at progressively realizing universal health coverage under an integrated national health system based on the principles and practice of primary health care. A key component of the reform was the implementation of family health community teams or, in Spanish, Equipos Comunitarios de Salud familiar (ECOSf). These teams were to be responsible for providing preventative and curative health care to a territorial jurisdiction comprised of about 600 families. The establishment of and investment in ECOSf were guided by a prioritization process across the 262 municipalities of the country that emphasized levels of extreme poverty and size of the vulnerable and disadvantaged population.

An exploratory analysis with data from the departmental level (i.e., a spatial aggregate of municipalities) showed that, three years after the ECOSf strategy was implemented, a non-trivial decrease in the magnitude of social inequalities in human resources for health (HRH) had taken place. The bar charts indicate a positive change in the distribution of HRH across subnational tertiles of wealth from 2009 to 2012, i.e., after ECOSf and the associated geographic targeting were introduced. More specifically, the range in HRH per 10,000 population between the poorest and richest 33 percent of the country's population decreased from -23.2 (i.e., 6.8 minus 29.9) to -9.7 (i.e., 15.7 minus 25.4) during that period.

Inequality in HRH can also be measured in terms of the concentration index. This is illustrated by the concentration curves. Along the x-axis are the departmental populations ranked from highest to lowest in terms of prevalence of extreme poverty. The corresponding concentration index decreased from 0.36 to 0.17 during the three-year period assessed, something which represents a marked reduction in inequality.

Contributed by Dr. Oscar J. Mujica and Dr. Carla Saenz (PAHO/WHO)[145, 146]

There are, of course, many additional ways to target groups. A quite different form of group-based, equity-promoting targeting relies on service selection. This form of targeting typically involves giving priority to services addressing conditions that disproportionally affect disadvantaged groups.[21] Conditions of this type include, for example, infectious diseases and tobacco-related illnesses. Other forms of group-based targeting include tailored information through public campaigns and the removal of legal barriers to coverage.[147]

As noted, delivery mechanisms that target individuals are also available.[144] Widely discussed among these mechanisms are fee exemption schemes, which can be seen as a form of targeted subsidy. In certain circumstances, such schemes promote UHC; in other circumstances, they impede that goal.[21, 144 148, 149] Therefore, the targeting mechanisms must be carefully chosen in each particular case. The broader aim of reducing out-of-pocket payments is discussed in chapter 5.

The advantages of targeting must also more generally be balanced against its disadvantages. Targeted approaches may sometimes be less efficient in generating health benefits, as certain populations can be more costly to reach. Other times, however, targeting of disadvantaged groups goes hand in hand with cost-effectiveness. This may be the case, for example, when the prevalence of ill health in the targeted group is higher or when the potential of simple, highly cost-effective services—such as antibiotics for pneumonia in children—has yet to be realized in that group.[139, 150] The optimal degree of targeting also depends on public support and financial sustainability. Historically, the move toward universal coverage mobilized support from the majority of the population, including the middle class.[151] If a large scheme becomes too narrowly focused on a subpopulation, the scheme may lose general support. This is particularly relevant when considering whom to include in pooled funding arrangements, where the funding base may depend directly and indirectly on the inclusion of the non-poor.

Conclusion

In line with the goal of UHC, countries must seek coverage for *everyone*. When coverage cannot be fully extended to everyone immediately, countries should strive to first reduce barriers for the following groups:

- low-income groups;
- rural populations;
- other relevant groups to the extent that they are disadvantaged in terms of service coverage or health.

This strategy of reducing inequalities in service coverage is integral to the pursuit of raising the general level toward universality.

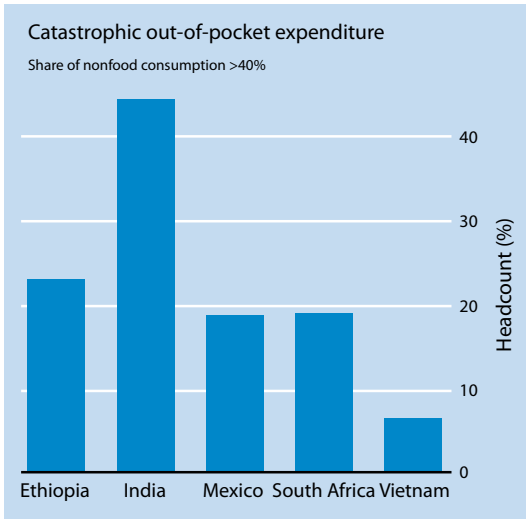
5 Reducing out-of-pocket payments

Universal health coverage (UHC) is centrally concerned with both access to services and financial risk protection. Large out-of-pocket payments represent financial risks and barriers to access.[i] Progress toward UHC therefore requires reform of the health financing system and a shift from out-of-pocket payment for services toward prepayment and pooling of funds. Countries are then faced with a critical choice of how to make such a shift. This choice involves two central questions: When reducing out-of-pocket payments, for what services and what subpopulations should these payments be reduced first? And when increasing prepayment and pooling, what criteria should determine how much money each person must contribute to the pool and what benefits each person can receive?

The challenge

An increasing body of evidence shows that most health systems fail to adequately offer financial risk protection and that out-of-pocket payments are a major cause for this.[139, 152, 153] One common indicator of financial risk and the bad consequences of such payments is the percentage of the population who experiences catastrophic out-of-pocket expenditures (based on a threshold share of 40 percent of nonfood household consumption) per year.[153] Figure 5.1 illustrates the problem in five countries by way of such an indicator.

Figure 5.1 Catastrophic out-of-pocket expenditures in five countries[t]



As seen from figure 5.1, a substantial proportion of the population in all of these countries experiences catastrophic out-of-pocket expenditures.

As indicated, a key underlying distinction is that between out-of-pocket payments and prepayments. Out-of-pocket payments are understood as payments for services or supplies made by the recipient at the time of delivery, and typically after the need for these services or supplies has become apparent.

[t] The figure is based on data from the World Bank[131]

[i] Access and barriers to access are more directly addressed in chapter 4.

Relevant services and supplies include consultations, tests, procedures, and medications. Out-of-pocket payments can be made to the providers or to some third party, for example, in the form of coinsurance or deductibles. Prepayments, in contrast, are made by the potential recipient of the services or supplies before delivery and typically before the need for a particular service is evident. Such payments include various taxes and premiums. Every national health system relies on a mix of out-of-pocket payments, prepayments, and other sources of revenue, but the ratio between out-of-pocket payments and prepayments varies considerably.

As suggested by figure 5.1, out-of-pocket payments may expose individuals and households to substantial financial risk, and there are many reasons why countries should reduce their reliance on such payments. One major reason is that such payments often impede access to needed services. Faced with out-of-pocket payments, many people have to delay utilization, seek suboptimal alternatives, or go without any service at all. Moreover, out-of-pocket payments constitute a barrier to access particularly for low-income groups, something widely considered unfair given the equal or often greater need and capacity to benefit from services among low-income groups. For those who do pay, out-of-pocket payments are often sufficiently large and unexpected to cause severe financial strain on the patient and his or her family. Such expenditures can be catastrophic and push people into poverty or those already poor into further destitution. This is illustrated in figure 5.1, and the effects of out-of-pocket payments are further illustrated in box 5.1.

Box 5.1 Impact of out-of-pocket payments on impoverishment in Uganda

In Uganda, universal health coverage (UHC) is a stated goal in the national Health Sector Strategic Plan.[154] The starting point is difficult, however. Although total expenditure on health represented 9.5 percent of the GDP in 2011, the absolute amount of total expenditure on health per capita was only $128 (international dollars for 2011). Of this, government and private expenditure on health represented 26.3 percent and 73.7 percent, respectively. Of the private expenditures, 64.8 percent was out-of pocket expenditures.[155]

The figure shows the impact of out-of-pocket payments on impoverishment in Uganda in 2010.

Impact of direct-out-of-pocket payments - impoverishment

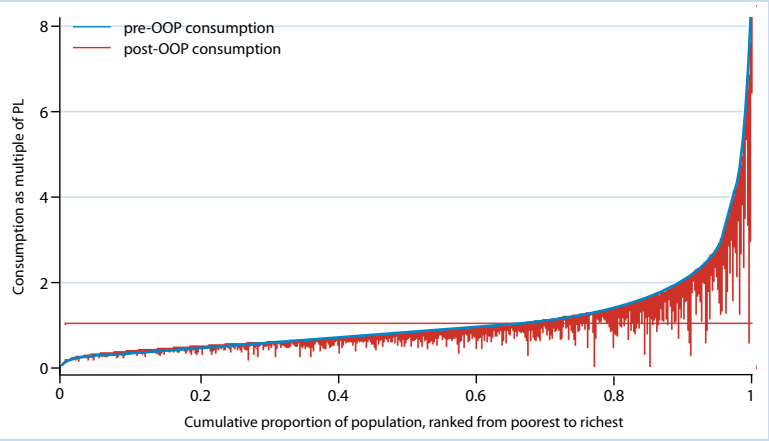


Figure adapted from Kwesiga et al.[156]

The figure illustrates how out-of-pocket payments increase poverty in Uganda not only by pushing previously non-poor individuals under the poverty line of $1.25/day, but also by increasing the depth and severity of poverty among those already poor. The figure also indicates how out-of-pocket payments—as illustrated by "paint drips" from the level of consumption prior to out-of-pocket payments—were mainly concentrated among the non-poor. However, the relatively low share of total out-of-pocket payments among the poor—again illustrated by the "paint drips"—does not imply that the poor are more protected from incurring such payments. Instead, the relatively low share is most likely the result of the poor not utilizing needed care because they cannot afford it.

Reducing reliance on out-of-pocket payments

Only when out-of-pocket payments fall below 15–20 percent of total health expenditures does the incidence of financial catastrophe and impoverishment fall to acceptable levels.[4] Fortunately, the proportion of out-of-pocket payments is amendable to policy intervention. Recent health financing reforms in several countries have demonstrated how reduction of out-of-pocket payments can reduce financial risk. Thailand provides a good example. After a UHC scheme was introduced in 2002, impoverishment due to out-of-pocket payments fell dramatically, as illustrated in box 5.2.

Box 5.2 Number of households impoverished by out-of-pocket payment for health services in Thailand (1996–2010)

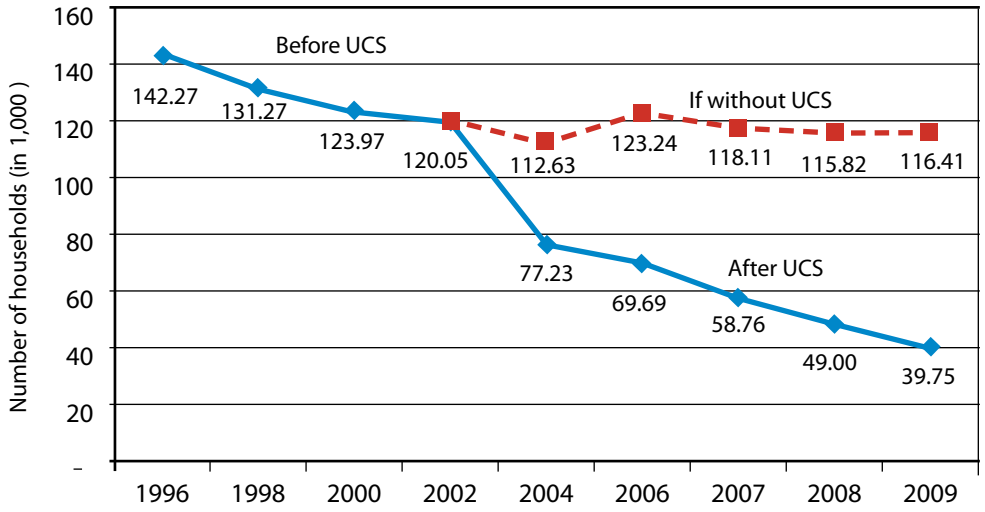


Figure adapted from *Thailand's Universal Coverage Scheme: Achievement and Challenges*[157]

In 2002, Thailand introduced the "UC 30 baht scheme," a tax-funded health insurance scheme designed to cover the approximately 47 million people who were not beneficiaries of the Civil Servant Medical Benefit Scheme (CSMBS) or the Social Security Scheme (SSS). As shown by the figure, the number of households impoverished—defined as being pushed under Thailand's national poverty line—due to out-of-pocket payments fell from about 120,000 in 2002 to 40,000 in 2009.

Several other countries pursuing UHC have experienced trends similar to that in Thailand.[96] Nonetheless, worldwide, an estimated 150 million people still suffer financial catastrophe each year due to out-of-pocket payments.[ii] Increased financial protection through the reduction of such payments is thus both feasible and clearly needed.

Increasing reliance on prepayment

Reduced reliance on out-of-pocket payments must come with increased reliance on prepayment. If providers cannot increase revenues from other sources, attempts to regulate out-of-pocket payments downwards can have negative, unintended consequences. These consequences include an increase in informal payments, supply-side shortages, and skimping on the quality of care by diluting, delaying, or removing services that cost more to produce than providers can recoup.

[ii] According to the World Health Report 2013.

Prepayment mechanisms have the potential to address many of the shortcomings associated with out-of-pocket payments, thus promoting both access and financial risk protection. This is primarily because such mechanisms allow for pooling of funds and consequently pooling of risk. The pooling of prepayments can take place in different settings, for example, in private and social insurance schemes, but the prepayments should be mandatory. Evidence at all national income levels shows that mandatory contribution mechanisms (taxation or mandatory social health insurance) are more efficient than voluntary mechanisms.[4] This is particularly because voluntary mechanisms are vulnerable to the problem of "adverse selection," whereby relatively "high-risk" elderly and sick individuals are more likely to join the pooled scheme than relatively "low-risk" young and healthy individuals.[158] UHC will normally require a degree of financial subsidy not only from the rich to the poor, but also from the young and healthy toward the elderly and unhealthy.[139] A mandatory system is required to ensure that the rich, young, and healthy fulfill their obligations of fairness and equity, since otherwise they may opt out of a pooled scheme that makes them to pay more than they receive in terms of personal benefits. Therefore, it is generally recommended that countries move toward mandatory prepayment with pooling.[4, 116]

Countries that want to reduce out-of-pocket payments can raise additional funds in multiple ways. In particular, additional funds can result from economic growth, increased mobilization of domestic resources, intersectoral reallocations, efficiency gains, and more external resources.[4, 19, 21, 107, 159] These various sources of funds are further described in box 5.3.

Box 5.3 Sources of additional funds

Additional funds can typically result from economic growth, increased mobilization of domestic resources, intersectoral reallocations, efficiency gains, and more external resources.[4, 19, 21, 107, 159]

As for economic growth, the Lancet Commission on Investing in Health projected real GDP growth per year at 4.5 percent for low-income countries, 4.3 percent for lower-middle-income countries, and 4.2 percent for upper-middle-income countries from 2011 to 2035.[21] If these projections come true and if countries make UHC a national priority, at least middle-income countries can finance all or most of the required expenditures from domestic resources.

As for increased mobilization of domestic resources, one particularly important option for countries to consider is increased taxation of tobacco. Such an increase is likely not only to increase revenue, but also to improve population health. For countries rich in minerals or other natural resources, increasing government revenue from this source is another opportunity that should be explored.

Regarding intersectoral reallocations, a related strategy is to reduce or eliminate energy subsidies and other unwarranted subsidies. This can, among other things, increase the fiscal space for public spending on high-priority health services.

As for efficiency gains, many promising strategies can be pursued. The Word Health Report 2010 lists ten leading causes of inefficiencies that could be addressed: underuse of generics and higher than necessary prices for medicines; use of substandard and counterfeit medicines; inappropriate and ineffective use of medicines; overuse or supply of equipment, investigations, and procedures; inappropriate or costly staff mix and unmotivated workers; inappropriate hospital admissions and length of stay; inappropriate hospital size (low use of infrastructure); medical errors and suboptimal quality of care; waste, corruption, and fraud; and inefficient mix or inappropriate level of strategies.[4]

Finally, as for external resources, many low-income countries will, in the foreseeable future, continue to need development assistance for health (DAH) to supplement domestic resources.[21, 107, 159]

Exactly what combination of financing mechanisms best facilitates the shift from out-of-pocket payment toward prepayment and thus progress toward UHC depends on a range of country-specific factors. Across these factors, however, research has clearly demonstrated, as described, that extensive reliance on out-of-pocket payment is a major obstacle to both access to services and financial risk protection.

Making the shift fairly

For countries seeking to shift from out-of-pocket payment toward prepayment with pooling, a critical issue is how to do so fairly. Central to this issue are questions related to priority when reducing out-of-pocket payments and to the criteria for the pool of funds.

Priority when reducing out-of-pocket payments

When reducing out-of-pocket payments, a crucial question is for what services and what subpopulations these payments should be reduced first.

For services, out-of-pocket payments should, if possible, first be eliminated for high-priority services. The rationale for such an approach was discussed for barriers to coverage in general in chapter 4. Criteria for high-priority services were addressed in chapter 3 and are related, among other things, to cost-effectiveness, priority to the worst off, and financial protection. Fairness suggests that out-of-pocket payments should at least not be a barrier to coverage for these most important services as coverage of these services should be truly universal.[iii] Services of somewhat lower priority, but still important for people, could—on the path to UHC—be financed through a greater range of financing mechanisms, including general taxation, voluntary, supplementary insurance, and out-of-pocket payments.

For subpopulations, fairness considerations motivate special attention to certain groups when expanding coverage, as suggested in chapter 4. More specifically, these groups include low-income groups, rural populations, and other relevant groups to the extent that they are disadvantaged in terms of service coverage or health and sometimes more generally. Regarding out-of-pocket payments, there is even a particular reason to first reduce such payments for low-income groups, since a given fee represents a greater barrier to access and a greater financial burden to these groups. In addition, such a policy response will reduce the extent to which out-of-pocket payments are regressive with respect to income.

In practice, decades of experimentation have shown that it is often difficult to effectively and efficiently exempt poor individuals from out-of-pocket payments.[4, 149] Part of the explanation is that differentiated copayment and exemption schemes typically involve difficult means testing and high transaction costs.[21, 149] Seeking financing mechanisms based on prepayment should therefore be the first priority, but these efforts can be combined with other ways of targeting disadvantaged groups, as described in chapter 4.

[iii] In addition, issues of demand must be taken into account when considering the level of out-of-pocket payments. For some high-priority services, and especially preventive services, demand does not properly reflect their importance from a public health perspective. For these services, there is an extra reason to eliminate out-of-pocket payments.

Criteria for the pool of funds

When increasing prepayment and pooling, a crucial question is what criteria should determine how much money each person must contribute to the pool and what benefits each person can receive.

Generally, the criteria for contribution and benefits should be devised to separate use of services from payment for services.[4, 35] This is especially important for high-priority services. Use and payment can be decoupled in various ways.[61] One particularly attractive combination of criteria, in line with the guiding considerations discussed in chapter 2, is to have mandatory payments generally increase with ability to pay while benefits received are primarily based on need.

Regarding the benefit criterion, there are several reasons why this should be primarily based on need. As discussed in previous chapters, central reasons relate to the importance of health and health services to individuals and society, the right to health, and the collective responsibility for affordable access.

In particular, there are good reasons for why use of services should not primarily depend on ability to pay. It is not fair that the poor are denied access to high-priority services simply because they are poor.

Regarding the contribution criterion, contribution according to ability to pay finds support in the 2000 and 2010 World Health Reports[4, 35] and in many theories of distributive justice in health care.[5, 160] Many further argue that contributions should be progressive with respect to income; that is, the rich should pay proportionately more than the poor.

Conclusion

Progress toward UHC requires a shift from out-of-pocket payment toward mandatory prepayment with pooling of funds. When making such a shift, countries should seek to do the following:

- first eliminate out-of-pocket payments for high-priority services;
- first eliminate out-of-pocket payments for low-income groups and other disadvantaged groups, if this can be done effectively;
- make contributions to the pool of funds generally depend on ability to pay and make use of services primarily depend on need.

This approach will promote fairer distribution of benefits and burdens, across high- and low-income groups, across the young and the elderly, and across the healthy and the sick.

6 Overall strategy and trade-offs

Each of the three preceding chapters addressed one central dimension of progress in the pursuit of universal health coverage (UHC). Against that background, an overall strategy for fair progressive realization of UHC can be outlined. This general strategy leaves room for several different pathways to UHC, but it also suggests that some trade-offs are unacceptable in most circumstances.[i]

Overall strategy

A three-part strategy can be useful for countries seeking fair progressive realization of UHC. Countries can do the following:

(a) Categorize services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to 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. These will often include low-income groups and rural populations.

When high-priority services have been covered for everyone or all reasonable measures to that end have been taken, steps (b) and (c) can be repeated for medium-priority services and thereafter for low-priority services.

The overall strategy makes clear that systematic priority setting and service selection are front and center in the pursuit of UHC. It is not only the total number of services that matters; it is crucial what those services are. The more important a service, the more important it is that the service is universally covered. Another central feature of the overall strategy is that it privileges the inclusion dimension, that is, the "people" axis of the UHC box illustrated in chapter 1. Countries should take all reasonable measures to include *everyone* as quickly as possible and not try to cover a very expansive set

[i] There may be certain circumstances in which the generally unacceptable trade-offs are acceptable. First, there may be circumstances in which a policy involving a generally unacceptable trade-off will yield vastly greater total benefits, in terms of coverage or health improvement, than any other alternative policy. Second, there may be circumstances in which the worse off will be better off in absolute terms from a policy involving a generally unacceptable trade-off than from any other alternative policy. It is sometimes argued, for example, that certain policies involving generally unacceptable trade-offs best ensure sustainability of the financing system in the long run. However, such claims must be very carefully assessed. In particular, it must be ascertained that all other feasible steps have been taken, and the evidence should be very strong and unambiguously suggest that those policies are best overall.

of services from the outset if this would impede that goal. The general strategy also provides guidance for how to pursue universalism. It recommends that countries include disadvantaged groups from the outset and make sure that these groups are not left behind. Since the poor represent one such group, this approach overlaps with "progressive universalism."[21, 143]

As part of this or any other overall strategy, countries must carefully make choices within and across dimensions of progress. These decisions depend on context, and several different pathways can be appropriate. However, when pursuing fair progressive realization of UHC, some trade-offs are generally unacceptable.

Trade-offs

A trade-off can be seen as a compromise between two desirable but competing considerations. It thus involves a sacrifice made in one dimension to obtain benefits in another. Ethical theory is not always fine-grained enough to specify which trade-offs are acceptable and which are not. However, the considerations outlined in the preceding chapters point toward some unacceptable trade-offs, within and across dimensions. More specifically, at least the following five trade-offs can be considered *generally unacceptable* and incompatible with fair progressive realization of UHC in most circumstances. In addition, the same considerations that rule out certain trade-offs suggest that certain other trade-offs are acceptable.

Unacceptable trade-off I: *To expand coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing out-of-pocket payments for low- or medium-priority services before eliminating out-of-pocket payments for high-priority services.*

High-priority services are the most important services, partly because they tend to be the most cost-effective and to benefit the worse off. It is therefore generally unfair to expand coverage for low- or medium-priority services before there is universal coverage for high-priority services or all reasonable measures to that end have been taken. For example, it would be unacceptable to expand coverage for coronary bypass surgery (plausibly not a high-priority service in low-income countries) before securing universal coverage for skilled birth attendance and services for easily preventable or easily treatable, fatal childhood diseases. Services of the latter kind include oral rehydration therapy for children with diarrhea and antibiotics for children with pneumonia.

Lack of coverage for high-priority services tends to be concentrated among disadvantaged groups. To first expand low- and medium-priority services in such situations is particularly problematic and unfair. High-priority services are also those for which it is most important that out-of-pocket payments are reduced. In most circumstances, out-of-pocket payments for those services should therefore be eliminated before such payments are reduced for other services.

The considerations that lead to the judgment that trade-off is unacceptable suggest that certain other, important trade-offs are acceptable. Specifically, they suggest that it is acceptable not to first address coverage gaps or inequalities in coverage for low- and medium-priority services if that would undermine efforts to expand coverage of high-priority services or to reduce inequalities in coverage of such services. For

example, less than universal coverage of certain advanced cancer treatments with marginal health benefits—and associated inequalities in access to those treatments—can be acceptable if necessary for securing universal coverage of highly effective HIV treatment. The unacceptability of trade-off I further indicates that it is acceptable not to reduce out-of-pocket payment for low- and medium-priority services if that would undermine efforts to reduce out-of-pocket payments for high-priority services. For example, out-of-pocket payments for open-heart surgery can be acceptable if they are necessary for removing out-of-pocket payments for cesarean sections.

Unacceptable trade-off II: *To give high priority to very costly services whose coverage will provide substantial financial protection when the health benefits are very small compared to alternative, less costly services.*

Coverage of very costly services can often offer substantial financial risk protection by reducing out-of-pocket payments. However, when the health benefits are very small compared to alternative, less costly services, there are at least two reasons why it would be generally unacceptable to give high priority to the very costly services. First, by so doing, one would sacrifice many health benefits that could otherwise have been secured with the same resources. This is unfortunate because health benefits are highly valuable by themselves, but it is also unfortunate from the perspective of financial risk protection because health benefits tend to provide such protection indirectly. Health improvements can prevent certain out-of-pocket payments downstream and can increase productivity and the income-earning potential in the beneficiaries and their families.[21] Second, even immediate financial risk protection can often be secured more cheaply and fairly than through coverage of very costly services with limited health benefits. One reason is that even small out-of-pocket payments for non-costly services can be a significant financial burden on the poor, and more of these services can be covered within a fixed budget.[21] In addition, it is also fairer to purchase financial risk protection for the poor and disadvantaged. These points were discussed in greater detail in chapter 3.

As indicated, there are several reasons why financial risk protection must be carefully balanced against other concerns in the selection of services. Financial risk protection can play many different roles in this context, while, at the same time, persistently motivating UHC and the reduction of out-of-pocket payments more generally.

The reasons why trade-off II is unacceptable suggest that certain other, important trade-offs are acceptable. Specifically, in many circumstances it can be acceptable not to cover very cost-inefficient services even when such coverage would provide substantial financial risk protection.

Unacceptable trade-off III: *To expand coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.*

It is difficult to justify expanding coverage for well-off groups before worse-off groups if the policies are largely similar in other respects. This is especially the case if the services in question are high-priority services, if the worse-off group is very badly off, or both. As discussed in previous chapters, to expand coverage for well-off groups first would typically conflict with ideals of equality and a special concern for the worse off.

These considerations suggest that certain other trade-offs are acceptable. For one, it is acceptable not to expand coverage for well-off groups if that would undermine efforts to expand coverage for worse-off groups. Moreover, the argument indicates that it could be acceptable to expand coverage for well-off groups before worse-off groups if the costs or benefits are vastly different. For example, expanding coverage for a given service from 90 to 100 percent in certain heard-to-reach areas can sometimes be extraordinary difficult and costly. If the resources involved could produce vastly larger improvements in coverage and health outcomes in areas that are only somewhat better off, that may be acceptable. However, it must be ascertained that all other feasible steps have been taken and that the evidence strongly and unambiguously suggests that those policies are the best overall.

Unacceptable trade-off IV: *To first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier.*

Not only the total number of people included in a scheme matters. Who those people are and who is left behind also matter. It would generally be unacceptable to include only formal workers and the non-poor in the early stages of the pursuit of universal coverage. Instead, as discussed, there are many reasons why informal workers and the poor should have priority in the early stages, to the extent that this does not jeopardize the financial sustainability of the scheme. One is the ideal that coverage and use of services should be primarily based on need and not on ability to pay or political power. More specifically, including informal workers and the poor from the outset can counteract "the inverse equity hypothesis." This hypothesis suggests that a new health intervention tends to increase inequities because it initially reaches those who are already better off.[161]

Unacceptable trade-off V: *To shift from out-of-pocket payment toward mandatory prepayment in a way that makes the financing system less progressive.*

One of the problems with out-of-pocket payments is that they tend to be regressive with respect to income; that is, the poor pay proportionately more than the rich. This was discussed in chapter 5. When shifting from out-of-pocket payment toward mandatory prepayment with pooling of funds, this shift should therefore be done in a way that does not make the overall financing system less progressive. This is supported by the ideal that contributions to the system should increase with ability to pay.

Beyond the generally unacceptable trade-offs, there are several constraints on the pursuit of UHC that do not involve a compromise between two desirable ends and thus are not trade-offs. Central among these constraints is the prohibition on discrimination based on race, ethnicity, religion, gender, political beliefs, and sexual orientation. Discriminatory practices of these types are morally and legally indefensible, as suggested by widely accepted ethical theories, human rights frameworks, and many bodies of law.[85, 162, 163] For example, it is impermissible to deny access to HIV treatment simply due to sexual orientation.

Conclusion

A three-part, overall strategy can be useful when countries are seeking fair progressive realization of UHC. More specifically, countries can categorize services into priority classes, first expand coverage for high-priority services to everyone, and, while doing so, ensure that disadvantaged groups are not left behind. As part of this or any other overall strategy, countries must carefully make choices within as well as across dimensions of progress. These decisions will partly depend on context, and several different pathways can be appropriate. However, when pursuing fair progressive realization of UHC, some trade-offs are generally unacceptable. Robust public accountability and participation mechanisms are essential when deciding on the overall strategy, specific pathways, and the appropriateness of central trade-offs.

Public accountability and participation

7

People should be at the center of the health system in all respects. This implies that people should be not only recipients of services, but also agents that actively shape the system and how services are financed and delivered. The preceding chapters addressed several substantive considerations regarding the critical choices on the path to universal health coverage (UHC). Although such considerations do inform fair progressive realization of UHC, the processes of choice and implementation are also crucial. Specifically, fair progressive realization of UHC requires robust public accountability and public participation.

The importance of public accountability and participation has long been appreciated. The WHO 1948 constitution states that "[i]nformed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people,"[164] and the 1978 Declaration of Alma-Ata asserts that "[t]he people have the right and duty to participate individually and collectively in the planning and implementation of their health care."[165] Accountability and participation have recently attracted renewed international attention and now figure prominently in numerous health initiatives and in the shaping of the post-2015 development agenda.[166]

Basic ideas

Accountability involves answerability and enforceability.[167] Individuals and institutions that are held accountable must give information about their decisions and actions, justify them, and face some type of sanctions in the event of misconduct. All actors that influence the health system and the pursuit of UHC should be accountable to the public in a meaningful way, but this is particularly important for national and local governments and service providers. The public's role is to actively hold the relevant actors accountable.

Public participation is the practice of involving members of the public in the agenda-setting, decision-making, and policy-forming activities of institutions responsible for policy development.[168] True public participation involves interaction and dialogue. It thus goes beyond situations in which institutions simply provide information to the public or simply obtain information from the public.

Public accountability and participation can each take numerous forms.[168-174] They can also be related in several ways and tend to reinforce each other: robust accountability can strengthen participation and robust participation can strengthen accountability.

Moreover, governments and other relevant institutions can be held accountable for ensuring that proper participatory processes are in place.[25, 175] Public accountability and participation are also related to—and partly overlap with—several other important ideas, including transparency, voice, inclusion, empowerment, and responsiveness.

Motivations

Strengthened public accountability and participation can facilitate fair progressive realization of UHC and benefit society more generally in basically three ways. These are through better policy decisions, more effective implementation of these decisions, and supplementary benefits from an improved process.[5, 176-178] As for the quality of decisions, strengthened public accountability and participation in policy formulation can improve policy decisions by making decision-makers more careful and disciplined, by making decisions sensitive to a wider range of needs and values, and by promoting consistency across decisions. Strengthened public accountability and participation can also make the implementation of decisions more efficient by addressing disagreements at an earlier stage and by facilitating ownership. Strengthened public accountability and participation in the implementation phase itself can further make the implementation of decisions more efficient by discouraging fraud, corruption, and waste and by promoting collaboration within the community.

Strengthened public accountability and participation are also valuable beyond the immediate quality of the decisions and the effectiveness of the implementation. Meaningful accountability and participation are crucial for fair and legitimate processes, can promote democratic values, and are key components of a human rights framework. Accountability and participation can also help build trust and facilitate public deliberation, education, and learning. In the longer run, these benefits also affect the quality of the choices and the effectiveness of implementation. Moreover, there is also evidence for a positive impact of participation on health and health-related outcomes.[136] However, across all these roles of public accountability and participation, it is important who the accountees and participants are. In particular, for fair progressive realization of UHC, efforts to strengthen accountability and participation should pay special attention to marginalized groups.

A human rights framework puts special emphasis on accountability and participation, both in the context of health and more broadly.[25, 175, 179-181] For accountability, a human rights framework requires that the state should be held accountable for what it does, how much effort it is expending (in terms of resources, for example), and how it is going about the process.[175] Since, in a human rights framework, the state is primarily accountable to its subjects (rather than to donors, for example), requiring policy decisions that affect people's rights to be justified and subjecting those justifications to public scrutiny is fundamental. Under human rights law, there should be accountability for the process through which health policy goals are reached. Therefore, there needs to be adequate monitoring and oversight, transparency, access to information, and meaningful public participation.[179] From this perspective, meaningful participation implies processes that empower and mobilize ordinary people to become engaged in political and social action that promotes realization of the right to health as well as other human rights.[25, 182]

Public accountability and participation are important throughout the health system and throughout the policy-making process. To illustrate how accountability and participation can be strengthened and facilitate fair progressive realization of UHC, it is useful to emphasize three parts of that process: policy formulation, policy communication, and monitoring and evaluation. In each stage, numerous accountability and participation mechanisms can be used. Some of these may require institutional reform or even new institutions.

Policy formulation

The previous chapters highlighted critical choices on the path toward UHC. Robust public accountability and participation are crucial when such choices are made and when policy are formulated. This requires that stakeholders can influence what is "up for contention" and not merely respond to a pre-set agenda.[180] Public accountability and participation in policy formulation can be promoted in numerous ways. One group of participatory procedures include citizens' jury, citizens' panel, consensus conferences, deliberative polling, and town meetings with voting.[168, 173, 174] These procedures are typically linked to one specific decision or a small set of related decisions and are often transitory. However, these procedures can also be integrated into more continuous decision-making processes and be used on a regular basis. Other permanent and institutionalized mechanisms for strengthening accountability and participation should also be considered. One type of such mechanisms is the formal or semi-formal integration of entirely civic entities into the decision-making process. Another mechanism is citizen or lay representation in regular committees, boards, or other decision-making bodies. Examples of these mechanisms are provided below.

At the overarching level, public accountability and participation are promoted by strengthening democratic governance, including general elections. However, robust accountability and participation also at this overarching level, require much more than elections. In particular, vigorous public debate and deliberation over policy formulation are critical.[5, 183] Accountability and participation can also be promoted in several more indirect ways, such as through strengthening legal rights and strengthening marginalized groups and civil society.[40]

The various mechanisms can be used to address the critical choices within and across the dimensions outlined in the preceding chapters. In particular, robust accountability and participation are important with respect to decisions over both financing and service selection. These decisions pertain to the distribution of contributions, including the role of out-of-pocket payments, and the distribution of resources from pooled funds. A proper approach to these issues can be facilitated by the many mechanisms outlined above. Among the more integrated approaches is, for example, participatory budgeting.[40, 184-186] Typically, such budgeting involves a process by which citizens, either as individuals or through civic associations, can regularly contribute to decision making over at least part of a public budget through a series of meetings with government authorities.[187] Among countries with substantial experience with participatory budgeting are Brazil, Cameroon, Peru, and Sri Lanka.[186] In Porto Alegre in Brazil, for example, one study reports that more than 100,000 people (8 percent of the population) were involved in the 1996 budget process.[184]

Regarding service selection, priorities must be set based on scientific evidence, ethical arguments, and public values. To properly integrate these elements, it is important to have explicit, systematic, and continuous processes for priority setting and health technology assessment (HTA). Many countries now have formal processes in which experts assess evidence for health interventions—often including evidence on clinical effectiveness and cost-effectiveness—in a way that promotes scientific accountability. These countries include Australia, Colombia, Denmark, Finland, Germany, Mexico, the Netherlands, New Zealand, Norway, Sweden, Thailand, the United Kingdom (UK), and the United Stated (US).[88, 94, 188, 189] Some countries have also sought to integrate elements of direct public participation into the process.[88, 94, 190] Among these countries is Thailand, whose priority-setting process is further described in box 7.1.

Box 7.1 Stakeholder involvement in health technology assessment (HTA) in Thailand

The Health Intervention and Technology Assessment Program in Thailand makes recommendations about which services to include in the benefit package. Among the criteria considered are the following: (a) size of population affected, (b) severity of disease, (c) effectiveness of health intervention, (d) variation in practice, (e) economic impact on household expenditure; and (f) equity/ethical and social implications.[94]

Building on well-established practices of health technology assessment (HTA) used worldwide,[191] several groups of stakeholders are involved in assessing evidence against predetermined criteria. In Thailand, four groups of stakeholders are involved: health professionals, academics, patient groups, and civil society organizations. These stakeholders are involved in all phases of the HTAs, including nomination of services for assessment, selection of services for assessment, and appraisal of services.*

A scoring approach—based on multi-criteria decision analysis (MCDA)—with well-defined parameters and thresholds is used to assess the service(s) in question against each criterion.[192] The rank order of services can be adjusted through deliberation among the panelists. This method has been used to assess, for example, interventions related to alcohol regulation, prevention of cervical cancer, prevention of maternal-to-child transmission of HIV, and retroperitoneal hemodialysis for end-stage renal disease and to decide what drugs to include on the essential medicines list.[94]

* Viroj Tangcharoensathien (Personal communication, interview with Thalia Porteny, June, 2013).

Policy communication

Another, related way for enhancing public accountability and participation, with respect to policy decisions and their implementation, is to provide clear information about approved policies to the public.[97, 193] This is particularly important for policies related to basic rights and entitlements, public services including health services, and public expenditure budgets. Obviously, only if people know what policies have been approved can there be genuine public debate. Clear communication of policy decisions is also important for monitoring and evaluation, as discussed below. However, such communication is valuable also in a third, more direct way. Clear information is critical to the full use of services and for citizens' ability to claim their rights and entitlements. This is especially the case for poor and vulnerable groups, which often lack information about policies that are vital to their lives.

Regarding UHC, it is critical that all important aspects of UHC reforms and policies are clearly communicated to the public. Against the background of the preceding chapters, one particularly important aspect relate to service selection and out-of-pocket payments. People need to know what services they are entitled to and at what

level of out-of-pocket payments. Only then can services be used to the full extent and true coverage be obtained.

One way to facilitate policy communication with respect to service selection and out-of-pocket-payments is to devise a list of services included and excluded and to make that list publicly available. Examples of countries that have defined priority services as part of UHC reform include Chile, Ghana, Mexico, Nigeria, Rwanda, Thailand, and Vietnam.[94, 95] For explicit lists to be valuable, however, it is important that priority services are well defined, justified, and repeatedly reexamined and updated in light of new arguments and evidence.

Another important aspect of health-system policies about which public information is essential is the approved health expenditure budgets. These budgets, with descriptions of budgeted allocations at the national, district, and local levels, should be widely disseminated. This will enable citizens to claim the services for which resources have been allocated.

Monitoring and evaluation

It is necessary but not sufficient to formulate good policies and to communicate them clearly. Robust public accountability and participation also require careful monitoring and evaluation of the implementation stage and the effects of the approved policies. Specifically, fair progressive realization of UHC requires monitoring and evaluation of resources, coverage, and health outcomes. In addition, the process of policy formulation itself can be monitored and evaluated, something which is further described in chapter 8.

Resources

With respect to resources for health services, it is important to monitor both how funds are generated and how they are used. Information about the current state of affairs and change over time can facilitate comparison with stated policy and inform public debate and future policy making. For example, the WHO Commission on Information and Accountability for Women's and Children's Health has recommended that, by 2015, countries should track and report, at a minimum, two aggregate resource indicators: total health expenditure by financing source and total reproductive, maternal, newborn, and child health (RMNCH) expenditure by financing source.[194]

To gather information, the System of Health Accounts (SHA) can be used.[195] The SHA is now the internationally accepted methodology for tracking contributions to the health system and health spending within countries. For example, the pattern and total amount of out-of-pocket expenditure can be monitored. Health accounts can also be used to gather information about the flow of resources across health-system levels, geographic areas, and types of services, such as drugs, public health interventions, diagnostic and curative services, and rehabilitation. Moreover, condition-specific allocations can be tracked, such as the proportion of resources going to HIV, TB, immunization, malaria, and chronic conditions. Overall, with a good, comprehensive system of health accounts in place, civil society can more easily follow, criticize, and challenge the patterns of revenue generation and resource allocation. Accordingly, such a system can strengthen public accountability and participation in health sector reform.

Coverage

Monitoring and evaluation of service coverage are obviously essential to accountability and participation in the specific context of UHC and to the pursuit of UHC more generally. The use of a comprehensive set of indicators enables the public to hold decision makers accountable for taking the right steps toward UHC. Indicators of service coverage and financial risk protection are needed, and the selection of specific indicators is an important, nontrivial task which is addressed in chapter 8. For most indicators, not only average levels, but also the distribution across relevant groups must be measured and reported.

Health outcomes

Among the chief motivations for UHC are the improvement of population health and the promotion of a fair distribution of health in society. Decision makers should therefore be held accountable for health outcomes, and accountability in this respect will be strengthened by thorough monitoring and evaluation of highly relevant outcomes. These are further discussed in chapter 8. Information on health outcomes constitute, of course, critical input to policy formulation also more directly. Again, both average levels and the distribution across relevant groups must be measured and reported. For example, information about profound health inequalities across socioeconomic groups or geographic areas can form the basis for civil society pressure for reform.

The role of institutions

To ensure robust accountability and participation, accountability and participation mechanisms must be institutionalized.[196, 197] Many countries that have succeeded in moving toward UHC—such as Mexico, Rwanda, Thailand, and Turkey—have created innovative institutions that promote accountability and participation.[47, 48, 94, 198] Moreover, some high-income countries have established national committees for priority setting in order to make the priority-setting process more transparent and more explicit and to better engage the public.[88]

As described, accountability and participation are highly relevant for several issues and several types of institutions. Although these issues and institutions are diverse, general frameworks exist that can be relevant for most, or all, of these. One widely accepted framework for legitimate decision making is Accountability for Reasonableness (A4R).[5, 97] This framework takes seriously the fact that there is often reasonable disagreement about values and their relative importance. People differ in their views about which values are important, how they should be interpreted, and how they should be balanced, and such reasonable disagreement exists within and across countries. Divergent views of this kind may underlie, for example, disagreements about how to best trade off different service selection criteria against each other. Key policy decisions on the path to UHC should therefore be made through a process that all citizens see as legitimate. Such a process should be transparent, the decisions and their reasons should be made public, and the public—through participation—should have ample opportunity to influence the outcomes of the process. More specifically, the Accountability for Reasonableness framework lays out four conditions that should be met and these are described in box 7.2. The framework has been explored in a range of contexts[5, 97] and can be crucial in facilitating fair and legitimate decisions on the path to UHC.

Box 7.2 The four conditions in the Accountability for Reasonableness framework[97]

- *Publicity Condition*: Decisions regarding both direct and indirect limits to care and their rationales must be publicly accessible.
- *Relevance Condition*: The rationales for limit-setting decisions should aim to provide a *reasonable* explanation of how the organization seeks to provide "value for money" in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a rationale will be reasonable if it appeals to evidence, reasons, and principles that are accepted as relevant by fair-minded people who are disposed to finding mutually justifiable terms of cooperation.
- *Revision and Appeals Condition*: There must be mechanisms for challenge and dispute resolution regarding limit-setting decisions, and, more broadly, opportunities for revision and improvement of policies in the light of new evidence or arguments.
- *Regulative Condition*: There is either voluntary or public regulation of the process to ensure that conditions 1–3 are met.

Conclusion

Fair progressive realization of UHC requires tough policy decisions. Reasonable decisions and their implementation can be facilitated by robust public accountability and participation mechanisms. Such mechanisms are essential in policy formulation and priority setting and specifically in addressing the three critical choices on the path to UHC and the trade-offs between dimensions of progress. Public accountability and participation are also closely linked to policy communication and monitoring and evaluation. To be truly robust, accountability and participation mechanisms must be institutionalized, and the design of legitimate institutions can be informed by the Accountability for Reasonableness framework.

8 Indicators of progress

For all countries, it is crucial to have information on health system performance. Specifically, such information is indispensable for making progress toward universal health coverage (UHC). Although it is impossible to capture the full complexity of coverage, a good set of indicators can guide policy and facilitate fair progressive realization of UHC. To this end, countries must carefully select a set of indicators, invest in the necessary information systems, and then properly integrate the information into policy making.[199]

Several recent and ongoing efforts attempt to delineate an optimal framework for monitoring and evaluation in the context of UHC.[129, 200-202] To promote fair progress, however, concerns for fairness and equity must be centrally positioned in these frameworks, especially in the selection of indicators.[i] Against the background of the preceding chapters, it is possible to give some direction for how this can be done.

Selection of indicators

In designing a framework for monitoring and evaluation, countries should select the set of indicators that can best facilitate fair progressive realization of UHC. When doing so, there are at least four central considerations:

- *The purpose of monitoring and evaluation*: Investing in health information systems is only valuable if monitoring and evaluation can guide local, regional, and national policy making, inform public debate, and help countries compare performance within their health system and against other countries at a similar level of development.
- *The goal of universal health coverage and beyond*: Indicators should be closely aligned with the goal of UHC. The set of indicators should reflect the degree of access to a comprehensive range of key, quality health services and the degree of financial protection related to these services. However, focusing too narrowly on the health sector may hamper the wider goals related to the level and distribution of health outcomes. Outcome indicators are therefore also needed.

[i] Work is under way in WHO, in collaboration with the Rockefeller Foundation, to identify a set of indicators on social determinants related to health, gender, and human rights for monitoring equitable progress toward UHC. The project specifically looks at monitoring barriers to UHC and determinants of health that have differential impact across populations. The project also focuses on areas for intersectoral action that support the advancement of progressive universalism; that is, reforms toward UHC that benefit disadvantaged populations at least as much as they benefit better-off populations

- *Data availability and quality*: The glaring lack of data in many countries and rapid changes in coverage necessitate a broad set of indicators that goes beyond the data currently available. For many low- and middle-income countries, the Demographic and Health Surveys (DHS) and the now outdated World Health Survey (WHS) are the main sources of data. Investments in more comprehensive, high-quality data collection systems are clearly needed.
- *Types of indicators*: The means and ends of UHC can be monitored and evaluated. A broad approach calls for at least four types of indicators: indicators related to the priority-setting processes and indicators of coverage, financial risk protection, and health outcomes. For the last three types, it is indispensable that not only average level is measured, but also the distribution across relevant groups.

Process indicators

As described in previous chapters, careful priority setting is crucial for fair progressive realization of UHC. The priority-setting process is hard to measure quantitatively, but a set of qualitative indicators can be useful.[34, 192, 203, 204] Among these indicators are those that reflect the existence of the following:

- an institution or entity within an institution (such as within the Ministry of Health) responsible for assessing and evaluating scientific evidence relevant for priority setting;
- procedures or decision-making bodies that involve citizens and key stakeholders in priority setting and provide reasons for priority-setting decisions;
- publicly available criteria for priority setting;
- publicly available descriptions of the high-priority services that people are entitled to and information about how these services are financed (with special emphasis on out-of-pocket payments).

This set of process indicators can be useful for strengthening public accountability and public debate, something which was discussed in chapter 7.

Indicators of coverage

Available data do not permit countries to fully monitor service coverage for all important services. Countries therefore have to select which services their indicators should be related to. To facilitate this task, countries can categorize services into priority classes, as described in chapter 3. Given the service selection criteria outlined in that chapter, a certain set of prevention and care services is likely to be among the high-priority services in most countries. This set covers services addressing communicable diseases, reproductive health, and nutrition and other noncommunicable diseases (NCDs)—including mental disorders—and injuries.

WHO and the World Bank Group (WBG) have developed a joint framework for monitoring progress toward UHC at country and global levels.[202] Building on this framework, a list of primary coverage indicators and a list of supplementary coverage indicators are outlined for illustrative purposes. Exactly what services the coverage indicators should relate to is an issue of considerable controversy, and the final selection must be sensitive to country context. Table 8.1 provides an illustrative list of primary coverage indicators that together target a wide range of conditions.

Table 8.1 Illustrative list of primary coverage indicators

Conditions	Indicators related to	Level/distribution
Communicable diseases and reproductive, maternal, neonatal, and child health conditions	1. Immunization	+/+
	2. Antibiotic treatment for suspected pneumonia	+/+
	3. Met need for contraceptives	+/+
	4. Basic obstetric and neonatal care with skilled birth attendance	+/+
	5. Comprehensive emergency obstetric and neonatal care	+/+
	6. Prevention of mother to child transmission (PMTCT)	+/+
	7. Antiretrovirals for HIV/AIDS	+/+
	8. Diagnosis and treatment for tuberculosis	+/+
	9. Insecticide-treated mosquito nets (where relevant)	+/+
	10. Prevention of malnutrition	+/+
Noncommunicable diseases	11. Care and treatment for schizophrenia and depression	+/+
	12. Primary medical prevention of CVD (risk > 35%)	+/+
	13. Implemented tobacco and alcohol regulation/ taxation/campaigns	
	14. Screening for cervical cancer	+/+
Injuries	15. Road traffic regulation and legislation	

As can be seen from table 8.1, the conditions emphasized go beyond communicable diseases and conditions related to reproductive, maternal, newborn, and child health (RMNCH) to also include noncommunicable diseases (NCDs) and injuries.[21, 202] The services for which universal coverage is sought plausibly target all these kinds of conditions. However, it is important to note that relevant data on NCDs and injuries are generally lacking.

Countries further down the path to UHC may find a list of supplementary coverage indicators equally relevant for policy making. One such list is illustrated in table 8.2.

Table 8.2 Illustrative list of supplementary coverage indicators

Conditions	Indicators related to	Level/distribution
Communicable diseases and reproductive, maternal, neonatal, and child health conditions	1. Hospitalization for severe birth complications, sepsis, pneumonia, malaria, and other infections	+/+
Noncommunicable diseases	2. Treatment for type 1 diabetes	+/+
	3. Preventive treatment for type 2 diabetes	+/+
	4. Hospitalization for myocardial infarction	+/+
	5. Acute medical treatment for stroke	+/+
	6. Treatment of epilepsy	+/+
	7. Treatment of acute renal failure	+/+
	8. Treatment of cervical cancer	+/+
	9. Treatment of breast cancer	+/+
	10. Treatment of stomach cancer	+/+
	11. Treatment of leukemia (adults and children)	+/+
	12. Palliative care	
Injuries	13. Prevention of injuries	+/+
	14. Essential surgery	+/+
	15. Intensive care for severe injuries	+/+

Information on each service, if available, is typically reported as overall coverage rates, i.e., the proportion of the total population covered for the service in question. As suggested, countries should also collect disaggregated data that show the distribution of coverage across relevant groups, including across wealth quintiles.[200] Such data are illustrated in table 8.3. Here, the coverage rates for skilled birth attendance for every quintile are shown for five countries. The variation across wealth quintiles is pronounced. In Ethiopia, for example, coverage for skilled birth attendance is 46 percent in the highest quintile and only 2 percent in the lowest quintile.

Table 8.3 Distribution of skilled birth attendance in five countries[131]

	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Inequality (CI)*	Average (%)	Inequality-adjusted coverage
Ethiopia	1.7	2.9	3.2	7.4	45.6	0.607	10.0	3.9
India	19.6	32.4	49.7	67.5	89.1	0.293	47.3	33.4
Rwanda	61.2	63.5	66.7	72.6	85.9	0.067	69.0	64.4
Colombia	84.4	96.8	98.8	99.4	99.5	0.036	94.9	91.5
Vietnam	58.2	86.2	95.1	97.1	99.7	0.101	85.2	76.6

* CI = Concentration index (range 0-1). With perfect equality, CI takes the value of 0.

The concentration index (CI) is a widely used indicator of distribution. It is analogous to the Gini index but uses a measure of socioeconomic status for ranking of groups. The CI is related to the concentration curve, which plots the cumulative proportion of the outcome variable against the cumulative proportion of the population ranked by a measure of socioeconomic status, and the CI equals twice the area between the concentration curve and the diagonal line of equality.[205, 206]

Data on average level and distribution of a service or set of services can also be combined into a summary indicator.[207] One such indicator, representing inequality-adjusted coverage, can be calculated as follows: inequality-adjusted coverage = m(1-CI), where m is the average service coverage rate for the population as a whole and CI is the concentration index. Inequality-adjusted coverage can differ significantly from non-adjusted coverage rates as the former is directly sensitive to the distribution of coverage. Such indicators can therefore help facilitate fair progressive realization of UHC.

It is important to note, however, that it is not only distribution across socioeconomic groups that matters. The distribution of service coverage across other characteristics, such as gender and area of living, should also be monitored.

Indicators of financial protection

The goal of UHC pertains not only to access; UHC is also centrally concerned with affordability and financial protection beyond their role as barriers to access. It is therefore crucial to monitor and evaluate the extent to which the health system offers such protection.[4, 14, 129, 200, 201, 205] The following three measures are found particularly relevant and are strong indicators of financial risk linked to out-of-pocket payments:[202]

- *Percentage of the total population that faces catastrophic health expenditure due to out-of-pocket payments*: Health expenditures are typically considered catastrophic for a household if they exceed a certain threshold, for example, 40 percent of nonfood household expenditures in a year.[200] In many countries, the relevant information is available from household expenditure surveys. Both level and distribution across groups should be monitored;
- *Percentage of the total population impoverished due to out-of-pocket payments*: This is defined as the proportion of the population, over a year, that is pushed below the poverty line due to out-of-pocket payments. In many countries, the relevant information is available from household expenditure surveys. Again, both level and distribution across groups should be monitored;
- *Proportion of out-of-pocket payments*: This is defined as the proportion of out-of-pocket payments relative to the total health expenditure. In many countries, the relevant information is available from national health accounts. The proportion of out-of-pocket payments is primarily linked to financial risk protection by a known high correlation between that proportion and catastrophic health expenditure and impoverishment. Evidence suggests that out-of-pocket payments typically have to represent less than 15 to 20 percent of total health expenditure before the incidence of catastrophic health expenditures and impoverishment falls to negligible levels.[4]

All these measures can be useful indicators of financial risk protection in monitoring and evaluating the progress toward UHC.[ii]

Health outcome indicators

Among the chief motivations for UHC are the improvement of population health and the promotion of a fair distribution of health in society. This suggests that health outcome indicators also provide relevant information for fair progressive realization of UHC. The value of such indicators is further underlined by the fact that many determinants of health are found outside the health system, including various social determinants. Health outcome indicators can reflect the level and distribution of such determinants and may also reflect imbalances in country efforts to address the various types of determinants. For example, imbalances between the efforts to improve the health system and the efforts to improve women's education or infrastructure to provide clean water may be reflected in overall health outcomes, at least in the long term.

At the macro level, the most relevant summary measures of health outcomes are life expectancy and health-adjusted life expectancy (HALE). Other important outcome measures include maternal mortality, under-five mortality, and stunting rates or other measures of malnutrition. As suggested in the preceding chapters, distribution is crucial also with respect to such outcomes. Accordingly, if a health outcome indicator such as HALE is used, the distribution of HALE should also be reported. Possible methods for reporting distribution of this outcome include bivariate and univariate measures of health inequality.[208] Some of these have, for example, been developed and discussed in the context of the Human Development Reports.[209, 210]

Conclusion

Monitoring and evaluation are essential for fair progressive realization of UHC. To this end, countries must carefully select a set of indicators, invest in health information systems, and properly integrate the information into policy making. The selection of indicators should be closely aligned with the goal of UHC and in most settings include at least four types of indicators: indicators related to the priority-setting processes and indicators of access, financial risk protection, and population health. The last three types of indicators should reflect not only average or aggregate levels but also the distribution.

[ii] Notice that these indicators have some limitations. For example, especially the first two indicators are not directly sensitive to under-consumption of health services due to lack of affordability.

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