



Defining Pathways and Trade-offs Toward Universal Health Coverage

Comment on “Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage”

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Abstract

The World Health Organization's (WHO's) World Health Report 2010, “Health systems financing, the path to universal coverage,” promoted universal health coverage (UHC) as an aspirational objective for country health systems. Yet, in addition to the dimensions of services and coverage, distribution of coverage in the population, and financial risk protection highlighted by the report, the consideration of the budget constraint should be further strengthened in the ensuing debate on resource allocation toward UHC. Beyond the substantial financial constraints faced by low- and middle-income countries, additional considerations, such as the geographical context, the underlying country infrastructure, and the architecture of health systems, determine the feasibility, effectiveness, quality and cost of healthcare delivery. Therefore, increased production and use of local evidence tied to the criteria of health benefits, equity, financial risk protection, and costs accompanying health delivery are needed so that to highlight pathways and acceptable trade-offs toward UHC.

Keywords: Universal Health Coverage (UHC), Equity, Financial Risk Protection, Budget Constraint, Priority Setting.

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The World Health Organization's (WHO's) World Health Report 2010, “Health systems financing, the path to universal coverage,”¹ proposed universal health coverage (UHC) as an aspirational objective for countries' health sector to rally around. In particular, using the metaphor of a cube, later coined as “the WHO cube,” the report highlighted three important dimensions for health systems to consider on the path toward UHC: (i) which health services should be covered; (ii) which populations should be covered; and (iii) what share of the direct health services costs should be financed by the public sector, public finance, and prepayment mechanisms (eg, social health insurance) vs. from out-of-pocket (OOP) expenditures financed by individuals and households. This third dimension directly relates to one of the fundamental intents of health systems which is tied to financial risk protection and the prevention of medical impoverishment.

The theme of UHC was recently included in the Sustainable Development Goals (SDGs) which were ratified by the United Nations General Assembly in New York in September 2015. Specifically, the third goal (SDG3), dedicated to health, “to ensure healthy lives and promote well-being for all at all ages,” includes a subtarget on achieving “UHC, including financial risk protection and access to quality, essential health services.”² Furthermore, the first goal (SDG1) endorses the objective “to end poverty in all its forms everywhere” by 2030, where financial risk protection in health can play a crucial role. Yet, in both the debate on the practical implications of UHC

and the discourse of the SDGs, there is limited emphasis on the “budget constraint.” In other words, we find little discussion of the fact that these grand objectives would have to be fulfilled with highly restricted financial resources, and that therefore, difficult choices and politically sensitive trade-offs, such as the ones described by Norheim,³ would have to be examined.

With five case studies, Norheim³ forcefully illustrates some of the difficult real-world situations which may be faced by policy-makers on the way to UHC. Even before ethical considerations are addressed, his descriptions fundamentally point us to the critical importance of the budget constraint, an essential element for decision-makers in charge of allocating resources on the way toward UHC. That is to say, a decision-maker should consider the following three dimensions in examining pathways toward UHC: (1) which services should be covered? (eg, interventions addressing non-communicable diseases vs. interventions tackling infectious diseases and maternal conditions); (2) which populations should be covered? (eg, rural vs. urban populations); (3) which costs should be financed by the public sector, through prepayment mechanisms or by direct OOP payments? (eg, which services should be exempted? what should be the size of the copayment for some services?). And all three dimensions ought to be considered within a certain budget, in other words they are constrained by the overall size of public financing dedicated to health.

Therefore, from the perspective of the analyst, the move

toward UHC may be best regarded as the evolution within a three-dimensional space given multiple constraints including the budget constraint. Using this schematic, the three-dimensional space can be defined along the three axes of services (*x*-axis), population coverage (*y*-axis), within which falls the issues of distributions and equity, and size of direct OOP payments (*z*-axis), within which falls the issues of financial risk protection and poverty reduction. Meanwhile, the allocation of financial resources along these three axes will be constrained by the disposable budget. Evidently, there exists an infinite number of directions to which one could move in this three-dimensional space; and, consequently, there is an infinite number of pathways which countries could take toward UHC. Nonetheless, critical judgments, whether inferred from an economic, ethical or political standpoint, will impose certain directions as opposed to others, within this three-dimensional space. For instance, Norheim³ utilizes his ethical appreciation and thus forbids certain pathways as he reflects on what would be unacceptable trade-offs in his opinion. Norheim explicitly imposes restrictions on the directions on the move toward UHC with respect to the axes of services, population coverage, and direct OOP payments. In particular, his unacceptable trade-offs are materialized by specific regions within the three-dimensional space where multiple constraints, including budget, operate. These discrete regions are for example delimited by distributions (eg, rural vs. urban populations) along the population coverage axis, or the categorization of high, medium, and low priority interventions along the services axis.

Importantly, careful thinking as how to move coincidentally along these three dimensions/axes should be given as countries attempt to fulfill UHC, and especially take into account the prior construction and idiosyncrasies of local health systems, the rapid changes in epidemiological profiles, and the fast urbanization of countries. Specifically, countries are facing a variety of constraints. First, there are important health system constraints: for example, a lack of health workforce and a sparse and uneven distribution of health facilities may prevent the delivery of key interventions including those ordinarily deemed most cost-effective. The scale-up of such interventions would require substantial investments in the redesign of the health system and hence would be prohibitively expensive. Second, there are contextual constraints: for instance, countries' infrastructure, such as the presence or the absence of a good network of roads and transportation means, is determinant for delivery and access to quality healthcare. As a result, due to a lack of good infrastructure, the marginal costs of healthcare delivery may become very large, or the health services provided might face quality issues and be ineffective (eg, vaccine cold chain being broken leading to reduced vaccine efficacy). On the other hand, some specific subpopulations (eg, the hard-to-reach and the poorest) may be facing a larger burden of disease and be most at need: for example, individuals in the poorest income quintile may be at a higher risk of infection from severe infectious diseases (eg, tuberculosis). Therefore, some of the trade-offs highlighted by Norheim might be impacted by the inclusion of some of these realities, pointing to the critical importance of local evidence for informed decision-making. Beyond, the selection of pathways toward UHC will be greatly influenced

by the underlying political and social forces. For example, pressures from the clinical sector, political constituencies, and the civil society may push for curative as opposed to preventive services.⁴ Likewise, a pro-rich bias toward the use of expensive treatments may be observed in many countries highlighting the influence of elites on the decision-making process⁵; and the development of universal public finance for healthcare delivery targeting specific segments of populations might be confronted with the rapid expansion of the private sector in low- and middle-income countries.⁶

Multiple criteria are to be examined when moving toward UHC, some of which were well-described in WHO's report on "Making fair choices on the path to UHC."⁷ Clear definitions about the criteria to be considered, complemented by tailored economic evaluation methods, such as "extended cost-effectiveness analysis,"^{8,9} which examine the impact of policy in multiple outcome dimensions (eg, health gains, distributional consequences, financial risk protection) per budget constraint, are needed.

Moreover, we require clear definitions and consensus about the meanings of "high priority services," "medium priority services," and "low priority services" so to enact transparent decision rules. Hence, similarly to epidemiologic information on the burden of disease, further investigation toward collecting systematic evidence on the financial burden of disease faced by households and families is urgent, so that health systems could also deliver "financial risk protection cost-effective" services.⁹ For example, one publicly financed service might provide high financial protection to a country's citizens because it is costly, whereas another intervention might provide similar levels of financial protection because it is cheap and prevents repeated moderately costly events (eg, malaria episodes). As a case in point, recent qualitative work by Miljeteig and colleagues (I. Miljeteig, A. Melkie, F. Berhane, E. Dessie, K.H. Onarheim, unpublished data) who interviewed both patients and providers in rural areas of Ethiopia demonstrated that the financial protection considerations were essential in the ultimate decisions taken by patients and providers in cases of both serious clinical and poverty consequences. Importantly, financial protection considerations should not be conceived under the lens of direct medical payments only, but also comprehensively add the aspects of transportation costs and indirect costs including time losses and wages foregone due to the onset of disease. As a result, policy-makers will always be confronted with trade-offs, such as the five unacceptable trade-offs which Norheim emphasizes, especially so on the way toward UHC. These five illustrations demonstrate the challenges ahead for countries who need a more contextualized evidence base before embarking on systematic decisions. The resulting informed priority setting process should involve the patients, the decision-makers, the public and the society as a whole.

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Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

SV is the single author of the paper.

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